Committed To Excellence | Working Together | Facing The Future

Frimley Health NHS
NHS Foundation Trust

# BOARD OF DIRECTORS - Meeting in Public

10.00am to 1.30pm on Friday, 4th March 2016
Board Room, Frimley Park Hospital

## A G E N D A

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| 10:00 | **1.** | **Welcome and Apologies for Absence** | | Chairman |
| | **2.** | **Declarations of Interest** | Oral | Chairman |
| | **3.** | **Minutes of the Previous Public Board Meeting held on 8th January 2016** | Attached | Chairman |
| | **4.** | **Action Log from Previous Meeting** | Attached | Chairman |
| 10:05 | **5.** | **Stroke Performance** | Presentation | Ottilia Speirs – Consultant, Stroke Unit |
| 10:20 | **6.** | **Chief Executive's Report** | Attached | CEO |
| **QUALITY** | | | | |
| 10:30 | **7.** | **CQC Inspection of Wexham Park Hospital Result and Action Plan** | Report | Chief Executive |
| 10:45 | **8.** | **Frimley Health NHS Foundation Trust Quality Improvement Plan** | Attached | Medical Director |
| **FINANCE AND PERFORMANCE** | | | | |
| 10:55 | **9.** | **Quality and Performance Report** | Attached | Directors of Operations/ Director of Nursing and Quality |
| 11:00 | **10.** | **NHS Staff Survey Report** | Attached | Director of HR and Corporate Services |
| 11:10 | **11.** | **Recruitment and Retention Update** | Attached | Director of HR and Corporate Services |
| 11:15 | **12.** | **Nurse staffing update** | Attached | Director of Nursing and Quality |
| 11:20 | **BREAK** | | | |
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| 11:30 | **13.** | **CIP Update**<br>**i) CIP Progress Report - Month 10**<br>**ii) 2016/2017 CIP Schemes** | Attached | Director of Operations, Frimley Park Hospital |
| 11:35 | **14.** | **Finance Report - Month 10** | Attached | Director of Finance and Strategy |
| 11:45 | **15.** | **2015/2016 Forecast Capital Out-Turn Report'** | Attached | Directors of HR and Corporate Services. |
| 11:55 | **16.** | **Security Contract** | Attached | Director of HR and Corporate Services |
| **GOVERNANCE AND COMPLIANCE** | | | | |
| 12:00 | **17.** | **Risk Assurance Register** | Attached | CEO |
| 12:15 | **18.** | **Infection Control Report** | Attached | Ian Fry - Director of Infection Prevention and Control |
| 12:25 | **19.** | **Annual Plan/ Draft Operational Plan 2016/17** | Attached | Director of Finance and Strategy |
| 12:30 | **20.** | **Clinical Governance Committee Report** | Attached | Medical Director |
| **OTHER BUSINESS** | | | | |
| 12:35 | **21.** | **Open Slot for Directors** | Oral | ALL |
| 12:40 | **22.** | **Board Evaluation** | Oral | ALL |
| 12:45 | **23.** | **Any Other Business** | | |
| 12:55 | **24.** | **Questions from Members of the Public** | | |

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| 13:00 | **25.** | **<u>Date of Next Meeting</u>**:<br><br>• Friday, 6th May 2016 at 10:00am at Frimley Park Hospital | | |

**NB: An 'Acronym Buster' has been included at the end of the Public Board papers pack.**

Frimley Health NHS
NHS Foundation Trust

**Minutes of a Frimley Health NHS FT Board Meeting in Public**
**Held on Friday, 8 January 2016 at 11 am**
**Boardroom, Frimley Park Hospital**

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| Present: | Mike Aaronson | Chairman |
| | Mark Escolme | Non-Executive Director |
| | Andrew Prince | Non-Executive Director |
| | Rob Pike | Non-Executive Director |
| | Dawn Kenson | Non-Executive Director |
| | Thoreya Swage | Non-Executive Director |
| | David Clayton-Smith | Non-Executive Director |
| | Andrew Morris | Chief Executive |
| | Martin Sykes | Director of Finance & Strategy |
| | William Jewsbury | Deputy Medical Director |
| | Nicola Ranger | Director of Nursing & Quality |
| | Lisa Glynn | Director of Operations (Wexham) |
| | Helen Coe | Director of Operations (Frimley) |
| In Attendance: | Susanne Nelson-Wehrmeyer | Company Secretary |
| | Louise Dodd (minutes) | PA to Chief Executive & Chairman |
| | Sarah Casemore | Deputy Director of Operations |
| | Pamela Morrison (item 5) | Head of Nursing, ITU & Theatres |
| | Subodh Tote (for item 5) | Lead Consultant, ITU |
| | Diane Dodsworth (for item 5) | Matron for ITU & Recovery |
| | Justin Woods (for item 5) | Consultant, ITU |
| | Suzy Armstrong (for item 5) | Matron, Day Surgery Unit |
| | Jane Hogg (for item 11) | Director of Integration |
| | Ian Fry (for item 17) | Director of Pathology |

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| **1.**<br>a. | **Welcome and Apologies for Absence**<br>Apologies were received from Janet King, Tim Ho, and Mike O'Donovan. | |
| **2.**<br>a. | **Declarations of Interest**<br>There were none. | |
| **3.**<br>a. | **Minutes of the Previous Meeting**<br>The minutes of the meeting held on 6 November were approved as a correct record. | |
| **4.**<br>a. | **Action Log from Previous Minutes**<br>*Caesarean Section Rates*<br>Nicola Ranger said that she had looked into the increase in C-Section rates and could assure the Board that there was no cause for concern as all the procedures had taken place due to legitimate reasons. | |

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| **5.** | **Ward to Board Presentation** | |
| a. | Pamela Morrison, Subodh Tote, Diane Dodsworth, Justin Woods, and Suzy Armstrong attended for this item. | |
| b. | Diane Dodsworth said that there had been an increase in admissions to ICU and that standards of care and quality had remained good. Hand hygiene results and attendance at mandatory training had improved and the department was now rated green for compliance against both targets. The one member of non-registered staff was booked for training, which would improve the non-registered training figures from 0% to 100% in the coming weeks. A lot of work had been undertaken around the root cause analysis of two C.Diff cases and a recent report had confirmed that the cases were unrelated and not considered to represent an outbreak. The main challenges related to limited housekeeping resources and delayed discharges from ITU to other wards. In addition, the sluice and relatives' rooms were in the wrong place. | |
| c. | Further to a discussion on ICU housekeeping requirements, Andrew Morris agreed that additional resources should be made available during the night to allow the bed spaces to be deep cleaned appropriately and turned around quickly. | **AVM** |
| d. | Andrew Morris said that a high level review of critical care capacity was required and that more level 3 beds would most likely be needed as the number of admissions increased. The reason for the delayed discharges from ICU to other ward areas was due to the overall hospital pressure. Bed capacity was a continuing challenge and a new 21 bed unit at Farnham hospital had opened to alleviate some of the pressure. He said that some patients were staying in hospital longer than needed due to long waits for post discharge packages of care and he hoped to have discussions with social care providers to speed up this process. Andrew Morris took the opportunity to thank ICU staff for working extremely hard to ensure that all patients were given top quality care despite challenging operational pressures. | |
| e. | In response to a query from Rob Pike, the Board was informed that the C.Diff. case apportioned to the Trust was due to the timing of the sample taken and the use of antibiotics in the months leading to ICU admission. | |
| f. | Thoreya Swage asked what actions had been taken to improve the results of the hand hygiene audit from red to green in a relatively short period of time. Diane Dodsworth said that empowering nurses to challenge others had had a real impact and, in addition, senior management had invited any non-compliers to discuss their actions in person. More education and training had taken place, with good examples of hand hygiene being used as training for other areas. | |
| g. | David Clayton-Smith noted that Band 6 recruitment was an issue for ICU. Pamela Morrison said that the Band 6 Sister development pathway had been so successful that the previous post holders had been promoted to Band 7. | |

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| h. | Suzy Armstrong reported that the main challenge for DSU was to improve patient experience and in consequence Family and Friends test results. Hospital pressures had led to half of the DSU1 discharge area being used by medical teams, impacting on the timely discharge of day surgery patients. The escalation area of DSU2 was currently being used as a ward due to operational pressures. Andrew Morris reiterated the importance of getting medically fit patients home in a timely manner and he hoped to develop an operating framework with social care providers to help alleviate some of the constraints on the hospital. | |
| i. | The Chairman thanked the ICU and DSU representatives for their excellent presentation and congratulated them on the high standard of care in their units. | |
| **6.** | **End of Life Care** | |
| a. | Bruce Montgomery, Consultant Urology Surgeon and Chair of the End of Life Committee, gave a presentation to the Board. | |
| b. | The Chairman informed the Board that both he and Mr Montgomery had participated in a service of commemoration for families of people who had experienced end of life care at Frimley Park. Around 250 people had attended; it had been a powerful occasion and it was evidently important for the families to have this opportunity. He was proud to be part of an organisation that went the extra mile in this way. He thanked Mr Montgomery for leading the Trust into being a provider of excellent end of life care. | |
| c. | Mr Montgomery described the various activity strands involved in the provision of excellent end of life care. He said that much had been achieved but that funding was now required for a bereavement coordinator to manage the organisation of future memorial services. | **NR** |
| d. | Mr Montgomery's presentation was well received by the Board. The Chairman highlighted the work of the chaplaincy team and the dedicated volunteers who supported this work, and suggested it would be good for the Board to hear about their good work. | |
| **7.** | **Chief Executive's Report** | |
| a. | The Chief Executive reported that the Trust was on track to meet all Monitor standards (4 hours, 18 weeks, cancer and C.Diff.) for quarter 3. The Trust had met all standards so far this financial year and was in the top performing 10% of hospitals nationally. | |
| b. | The NHS had secured a funding increase of £3.8b nationally and the efficiency requirement would be 2% with a tariff uplift of 3.1%. The savings requirement for the Trust would be 2% (a reduction from 4%) for every year until 2020. These changes provided the Trust with an opportunity to reduce the underlying deficit further and to deliver an improved financial position. In 2016/17 the Trust was planning to deliver a saving of £24m: £12m to meet the national savings target and the other £12m to address the underlying deficit. If these savings were achieved, the deficit should be reduced back to the original five year plan projection. | |

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| c. | The CQC report for the recent inspection at Wexham Park was expected within the next fourteen days. | |
| d. | Industrial action by junior doctors in relation to proposed contract changes would consist of a one- and a two-day strike in January and a two-day strike in February – when junior doctor support to emergency care would also be withdrawn. Concerning the first of these, scheduled for 12 January, contingency plans were in place for Frimley, Wexham, and Heatherwood sites with appropriate consultant cover arranged. | |
| e. | A hyper acute heart attack service had been approved by commissioners for Wexham Park from April 2016. Patients would no longer need to travel to other hospitals for specialist heart attack services out of hours. | |
| f. | Rob Pike noted that the £1.3m spend for a CT scanner at Heatherwood was a good investment and would pay for itself in a short time because patients would not need to travel elsewhere for this service. | |
| g. | Making reference to the expansion of Surrey Pathology Services (SPS) to include five District General Hospitals (most recently Royal Berkshire Hospital), Rob Pike said that Ian Fry, Director of SPS, deserved credit for his excellent leadership. Millions of pounds would be taken out of the NHS budget as a result of partnership pathology services. | |
| h. | Andrew Prince queried whether the national funding increase was linked to successful integration across local services and how these changes would affect Frimley Health. Andrew Morris responded that the Trust would be part of three larger health systems and all would be working together to achieve financial balance and new models of care. The Trust and local CCGs were interested in working differently and exploring ways to integrate local health services. The agenda for the NHS was to move from a competitive environment to collaborative working and discussions were needed on where the funding would be best placed to ensure improved performance across the wider health economy. | |
| i. | Thoreya Swage asked the Chief Executive for his thoughts on the intention of local authority partners to raise Council tax by 2% to fund improvements to social care. The Chief Executive said that local pressures included the reduction of local authority nursing home places due to a cut in funding in this area; this clearly had a major impact on hospitals. | |
| **8.** | **Patient Story** | |
| a. | Nicola Ranger presented a story relating to a patient treated at Frimley Park Hospital. The patient's wife had previously experienced poor quality care at Frimley Park and the patient and his family had been unsure about whether his care should be provided by the same hospital in which they had encountered problems in the past. The Patient Advice and Liaison Service (PALS) had been aware of the previous issues and had communicated with the family throughout the patient's treatment process. The patient had been happy with the PALS and treatment received so far. | |
| b. | Nicola Ranger said that the story reflected the work undertaken by PALS to break down the negative perception of Frimley Park by the family, which | |

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| | had built confidence in our services. She stressed the importance of taking a family's concerns seriously and ensuring that any future contact with the hospital was managed proactively for a positive outcome. Special thanks should be afforded to the PALS officers, who provided an excellent service. | |
| **9.** | **Quality Improvement Plans (QIPs)** | |
| a. | William Jewsbury noted that the Frimley Park and Wexham Park Quality Committees and documentation would be merged with effect from February. | |
| b. | The Frimley QIP highlighted key issues relating to emergency pressures, out of hours staffing/agency usage and on-going work streams on acute kidney injuries, sepsis and completion of the WHO checklist. No new work streams had been identified and one item relating to safeguarding actions was complete and would be removed from the QIP at the next meeting. | |
| c. | Referring to the duty of candour, Martin Sykes asked whether an embedded policy was nearing completion. Nicola Ranger responded that a framework was in development with the Mortality and Morbidity groups, which were working on the definitions of 'moderate harm'. The Board was assured that the Trust was meeting its mandatory obligations regarding candour; however, it was agreed that being open and honest with families because it was the 'right thing to do' was the main driver behind this piece of work. | |
| d. | The Wexham QIP highlighted key issues relating to auditing of agency staff, recruitment of nursing staff, skill mix for medical staff, and feeding back learning from mistakes into the organisation appropriately. Immigration issues were on-going for the nurses recruited from the Philippines. The Board agreed that a full report on recruitment should be presented to the Board of Directors meeting in March. | **JK** |
| e. | Rob Pike noted that some of the action dates had passed but labelled as 'on target' and that this needed some attention. | |
| **10.** | **Quality and Performance Report** | |
| a. | Nicola Ranger advised that a 'never event' was under investigation relating to the mislabelling of an X-ray. There had been some falls reported due to patients wishing to use the bathroom on their own and then falling over. There had been no recurrences of C.Diff. on the Wexham Park site. | |
| b. | The Trust was beginning to see an improvement in stroke performance, although some more work was required in this area. The Board asked to see a report on stroke, which should include the Trust's performance nationally and the plans to improve performance further over the next twelve months. | **HC** |
| c. | Dawn Kenson said that she had undertaken a quality visit to the stroke unit and that positive feedback had been received from patients. | |
| d. | Andrew Prince and Thoreya Swage asked if any data was available on the | |

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| | reasons behind readmissions. William Jewsbury responded that patients returned to hospital due either to the original medical condition or sometimes to an unrelated condition, but specific data was limited. Telephone helplines had been put in place to encourage patients to contact the medical teams directly instead of attending A&E. | |
| e. | Nicola Ranger reported a reduction in complaints received at Frimley Park. There had been an improvement in response times to Wexham Park complaints. | |
| f. | Helen Coe said that performance against the maximum six week wait for a diagnostic test had been achieved. The Trust had also achieved the A&E 4 hour standard and 18 week target for November and December. The industrial action planned by junior doctors could have a negative impact on the Trust's ability to maintain this level of performance. | |
| g. | Turning to the workforce part of the report, Helen Coe said that staff turnover had reduced overall; however, nurse turnover at Wexham Park had slightly increased. Some of the nurses recruited from overseas were starting work and additional incentive schemes such as 'recruit a friend' had yielded positive results. The Trust was actively recruiting on social media. The Board asked to see a report on the cost benefit of the recruitment and retention schemes against the cost of staff leaving. | **MS** |
| h. | Lisa Glynn reported that the CQUIN performance was achieved for quarter 2 and was on track to be achieved for quarter 3. | |
| **11.** | **Integration Update** | |
| a. | Jane Hogg, Director of Integration, presented the report, which informed the Board of progress against the integration plan and highlighted the focus of key work streams going forward. Good progress had been made on quality improvement and the governance structure. | |
| b. | The main challenges for integration were capacity for cross site working, underlying processes, and bringing the policies together. Clinically, there had been some cross site working relating to end of life care, whereby staff were learning from each other and making improvements. | |
| c. | The Trust had hosted a visit from Monitor in December when the integration plan had been scrutinised and no causes for concern had been identified. | |
| d. | Referring to the support the Trust continued to receive from Ernst & Young (EY), Andrew Prince asked when the Trust would be able to transition to only using its own resources. Jane Hogg responded that more EY support was needed to ensure a robust CIP plan was secured. The majority of EY staff had been replaced with interims or fixed term posts and the Trust planned to create a project team to take on the work of EY in coming year. | |
| e. | The Chief Executive said that the integration would be complete when the organisation had a unified culture; then and only then could the Trust move into 'business as usual'. | |
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| **12.** | **Cost Improvement Plan (CIP) Progress Report – Month 8** | |
| a. | Helen Coe reported that the Trust had delivered £2.336m against a plan of £2.324m, an over performance of £12k, in Month 8. | |
| b. | The year to date position was that the Trust had achieved 94% (£15m) of the total planned position of £16.7m. | |
| c. | The CIP target for 16/17 was £26.1m and at present, £24m worth of schemes had been identified. | |
| d. | The Board noted the good performance against the CIP targets. | |
| **13.** | **Finance Report** | |
| a. | Performance was on track against the mid-year submission to Monitor. Pay and non-pay were performing to plan and the year-end forecast was held at £12m, which would now reduce to £2m, as the Department of Health had agreed that the Trust would be allowed to access an additional £10m of deficit funding in the current year and a further £5m in 2016/17. The capital programme was, however, behind plan. This was partly due to planning issues with the Wexham Park new car park, and there had also been some delay on project work at Frimley Park. The main risk to the plan was agency overspend, which was not reducing at the planned rate. | |
| b. | The Chairman said that, during the Board meeting in private, the Board had discussed the capital plan underspend and the reasons for this, which were partly about capacity. The Executive team had been asked to satisfy the Board that the plan could be progressed. The Trust could not afford to be behind, especially if delays had a negative impact on patient experience. | |
| **14.** | **Board Objectives Quarter 3** | |
| a. | The Chief Executive presented progress against the Board Objectives for quarter 3. The Trust was performing well against a challenging operational environment. | |
| b. | The Chairman reported that as a result of changes to the Monitor finance reporting system, and given the current deficit, the Trust's rating had slipped from a 4 to a 2. However the injection of additional deficit funding from the Department of Health would redress this and allow the Trust to return to a Monitor rating of 4. Monitor was aware of the Trust's plans to improve the deficit position and had confirmed in writing that no investigatory procedures would be commenced against the Trust at this time. | |
| **15.** | **Quarterly Declaration** | |
| a. | Martin Sykes tabled the draft submission to Monitor, which recommended that the Board declare it would not meet a '3' for financial risk in quarters 3 and 4. There were also risks around achieving the 4 hour A&E target and the 18 week target due to the industrial action by junior doctors. | |

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| b. | Martin Sykes agreed to circulate a final version of the document for e-approval by the Board. | **MS** |
| **16.** | **Risk Assurance Report** | |
| a. | Andrew Morris presented the Trust-wide Risk Register for December, noting that one new risk relating to succession planning had been added since the previous iteration. | |
| **17.** | **Infection Control Report** | |
| a. | Ian Fry, Director of Pathology, presented the two-monthly Infection Control Report. | |
| b. | There had been one post-48 hour MRSA case at Wexham Park Hospital, which was agreed to be unavoidable at the Post-Infection Review meeting. Since April 2015 there had been 36 Trust-apportioned cases of C.Diff against a full-year target of 31 (21 at Wexham Park Hospital and 15 at Frimley Park Hospital). Root cause analysis of the cases to date had identified 11 lapses in care, 10 relating to antibiotic prescribing that did not comply with Trust guidelines, and one relating to a lack of hand hygiene consumables in a side room at Frimley Park Hospital. There had been two Trust apportioned cases on ICU at Frimley Park that had met the definition for a C.Diff. outbreak; however, the Public Health England laboratory had advised of an error in their calculations and the two cases were now considered unrelated and the status of 'outbreak' had been revoked. | |
| c. | Turning to hand hygiene, results from the most recent audit demonstrated 91% compliance at Frimley Park and 81% compliance at Heatherwood and Wexham Park. There had been an improvement from all departments at Frimley Park, with the exception of unregistered nurses and ancillary staff, where the results remained low at 84% and 85% respectively. The decline in performance at Wexham Park was of concern. Observations had shown that the greatest number of opportunities for hand hygiene was missed when staff members wore gloves – thinking that this was sufficient - and as a result additional training sessions were in place to reinforce best practice for glove removal. Compliance remained challenging overall and progress was slow despite much effort from the infection control and senior management teams. It was important that the ward leadership empowered staff to challenge and to remind others about the importance of hand hygiene. The Board noted and was sympathetic to Ian Fry's suggestion of involving patients and relatives in the monitoring of hand cleaning on the wards. | |
| d. | To date, there had been 356 cases of E.coli, the majority of which were community onset infections associated with non-healthcare related UTI. | |
| e. | In terms of antibiotic prescribing stewardship, there had been collaborative work by Microbiology and Pharmacy to align the antimicrobial policies across all three sites. New guidelines had been launched in November. At Frimley, the quarterly audit had found that compliance with the antibiotic care bundle had improved to 74%. The most recent data from Wexham | |

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| | Park and Heatherwood was the September audit and the results had previously been reported to the Board. | |
| f. | The Chief Executive asked the Board to note that the C.Diff. target was no more than 31 lapses in care, not 31 cases in total. The Trust currently had reported 11 lapses in care and 36 total cases. | |
| g. | The Chairman thanked Ian Fry for his excellent leadership of the Partnership Pathology service, which had been noted earlier in the meeting. | |
| **18.** | **Annual Insurance Update** | |
| a. | Nicola Ranger introduced the report, which informed the Board that the Trust would continue with membership of the Clinical Negligence, Liability to Third Providers and Property Expense schemes offered by the NHS Litigation Authority. | |
| b. | There had been a significant increase in the cost of the Clinical Negligence Scheme cover for the Trust from April 2015, when the NHSLA assessment level discounts had been stopped. Martin Sykes confirmed that the Trust had factored this cost pressure into the Trust's business plan. | |
| c. | The Board considered itself assured that the Trust had the appropriate level of insurance cover. | |
| **19.** | **Open Slot for Directors** | |
| a. | The Chairman reported that the Trust had received some unwelcome media attention as a result of an article in the Daily Telegraph about increases to executive pay in the NHS. FHFT had featured prominently because salary levels had been increased significantly to reflect the increased responsibilities accruing from the acquisition of Heatherwood and Wexham Park NHS FT. The Trust had released a statement to the media. | |
| b. | Andrew Prince, in his capacity as Chairman of the Performance and Remuneration Committee (PRC), informed the Board that the focus of the article had been differences in executive salaries in 2015 compared to the previous year. The role of the PRC, a sub-committee of the Board with membership consisting of NEDs including the Trust Chairman, was to determine the remuneration for executives and tier 2 managers. Every two years, the PRC sought advice from external remuneration specialists to benchmark the roles in comparable organisations nationally, particularly the NHS. Andrew Prince advised the Board that in the run-up to the acquisition the PRC had sought this specialist advice. The subsequent changes to executive director and senior manager remuneration had taken into account the doubling in size of the organisation and the major organisational change required, in particular the management of three sites instead of one site. The PRC had taken the decision to cease the relatively small bonus scheme for executives whilst setting base salaries that were appropriate to the new roles for the enlarged organisation. It was worth noting that the level of Board costs was now substantially lower than the aggregate of the two legacy organisations. Andrew Prince | |

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| | concluded that in establishing the executive salaries the PRC had taken account of the requirements and complex demands of the new organisation and stood by the decisions made in accordance with best practice. | |
| c. | The Chairman added that the Trust had reported the remuneration of the executive directors in the Annual Report 2014/15, which included the first six months of the new organisation. The Trust had a robust and respectable process for determining executive level remuneration and he was sure he spoke for the non-executive directors in saying he believed that the executives were appropriately remunerated for the very challenging and complex roles they filled. | |
| **20.** | **Board Evaluation**<br><br>The Board agreed that the meeting had been long but productive with appropriate time and attention afforded to some very important issues. This was gratifying in view of the decision to have a longer Board meeting in public every other month, rather than a shorter meeting every month under considerable time pressure. The Ward to Board and End of Life presentations had been especially well received; the latter was a powerful reminder of the fundamental purpose of the organisation. The Board noted with appreciation the large audience made up of the members of the public and governors. | |
| **21.** | **Any Other Business**<br><br>Rob Pike asked whether Frimley Health had anything to learn from the recent press reports regarding processes and investigation of unexpected deaths at Southern Health Foundation Trust. Andrew Morris replied that Frimley Health had always held mortality and morbidity meetings at which unexpected deaths and complications were routinely discussed. At a Trust wide level, mortality rates and complications were monitored by the Medical Director using the CRAB and other data. Although FHFT worked with Southern Health, this was in the area of community services, whereas the investigations had concerned their work in mental health; there were therefore no obvious implications for FHFT. | |
| **22.** | **Questions from Members of the Public**<br><br>*William Shambrook – Public Governor*<br>In response to the Telegraph article Mr Shambrook commented that the executives should show the public that they are 'value for money' and showcase their achievements. The Chairman replied that the whole organisation contributed to performance and that there was a natural reluctance at FHFT to emphasise individual, as opposed to team, performance.<br><br>*Sylvia Thompson – Public Governor*<br>Dr Thompson said it was important to acknowledge the contribution in setting executive pay levels of the non-executive directors, who had exercised their responsibilities in an independent manner in line with the Constitution, although it might be hard to get the public to understand this. | |

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| | The Chairman thanked her for this comment and said that the Directors and Governors had a shared responsibility for ensuring that the system worked in the way it should and communicating this to stakeholders. This would be discussed further at the forthcoming BoD/CoG workshop in January.<br><br>*Shalini Gupta – Member of the Public*<br>Ms Gupta advised that the capped agency rates would be implemented in three stages. The first stage had taken place in November, the second was due in February, and the third in April 2016 to coincide with the new financial year. | |
| **23.** | **Date and Time of Next Meeting**<br><br>Friday 4 March 2016 at 10.00 am at Wexham Park Hospital. | |

Frimley Health NHS
NHS Foundation Trust

# Board of Directors – 04 March Action Log

| Meeting | Minute Ref. | Action | Status | Lead |
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| **8th January 2016** | 5.c | *Ward to Board*<br>Further to a discussion on ICU housekeeping requirements, it was agreed that additional resources should be made available during the night to allow the bed spaces to be deep cleaned appropriately and turned around quickly. | To be clarified as an amendment to the Minutes | Andrew Morris |
| | 6.c | *End of Life Care*<br>funding was now required for a bereavement coordinator to manage the organisation of future memorial services. | | Nicola Ranger |
| | 9.d | *Quality Improvement Plans (QIPs)*<br>a full report on recruitment should be presented to the Board of Directors meeting in March. | On the agenda | Janet King |
| | 10.b | *Quality and Performance Report*<br>The Board asked to see a report on stroke, which should include the Trust's performance nationally and the plans to improve performance further over the next twelve months. | Presentation on the agenda | Helen Coe |

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| | 10.g | The Board asked to see a report on the cost benefit of the recruitment and retention schemes against the cost of staff leaving | On the agenda –recruitment report | Janet King |
| | 15.b | *Quarterly Declaration*<br>Martin Sykes agreed to circulate a final version of the document for<br>e-approval by the Board. | Completed. | Martin Sykes |

Frimley Health NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**
**4 March 2016**

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| Report Title: | **Chief Executive Report** |
| Agenda Number: | 6. |
| Report Purpose: | The brief the Board on current issues and developments. |
| Executive Lead: | Andrew Morris, Chief Executive |
| | **Performance and Finance**<br><br>FHFT is on track to meet all of the Monitor standards for this quarter except for 4 hours. In January, the Trust out turned 92.1% which was ranked 25th best out of 136 organisations. Only 5 hospitals in England achieved 95%. Although the weather has been relatively mild there has been an increase in activity which has adversely impacted on performance. Both sites have experienced spikes in ambulance conveyances with highly acute patients which have resulted in delays in getting patients into a bed. Frimley and Wexham have struggled to cope with the workload but have done relatively well keeping performance closer to the standard of 95% than most. The staff have gone the extra mile to provide as timely as service as possible and without their sterling efforts the position would have been far worse for January and February. The position as at 26th February was 92% for the month and 92.2% so far for the quarter. The 18 week, cancer and c.diff standards are still being met.<br><br>The financial position for the period April to January remains relatively stable with the deficit on track to decrease from £14m to £12m. The Department of Health has confirmed a transfer of unused elements of the transaction funding package for Wexham to cover £10m of the £12m deficit for 2015/16. In addition, Monitor has asked most Trusts to move capital funds to revenue to ensure that the NHS keeps within its £1.8b control total set by the Treasury for this financial year. For FHFT the requirement is to transfer £3m of capital funds to revenue which should result in a planned target surplus of £1m for 2015/16.<br><br>**CQC Inspection Report Wexham Park Hospital**<br><br>The CQC has published its report following its inspection of Wexham Park Hospital in October 2015. It was rated in February 2014 as Inadequate. Wexham Park achieved an overall rating of Good. Only a handful of Trusts have gone from a rating of Inadequate to Good in one step and it is rare not to have any service or domain rated as Requires Improvement. Also the Hospital's Critical Care and Emergency Department Service were both rated as Outstanding along with the Leadership arrangements. |

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| | Indeed Sir Mike Richards, Chief Inspector of Hospitals, said "Remarkable progress has been made since our previous Inspection. Indeed this is undoubtedly the most impressive example of improvement that the CQC has observed since our new to inspection started in September 2013".<br><br>FHFT now has the best rating from the CQC for a multi-site Trust in England with Frimley Park rated as Outstanding, Wexham Park Good and Heatherwood Good. The CQC is reviewing its arrangements for future inspections and hospitals with a rating of Good and above are likely to have a more light touch approach and so it may be longer than 18 months before the three sites will be inspected again.<br><br>**Junior Doctors Contract**<br><br>It is most unfortunate that the dispute has continued. Junior doctors are the "lifeblood" of any hospital and we rely so much on their support and commitment. This is the first time since the 1970s that junior doctors have gone on strike. The Government now intends to impose the new contract. With the exception of the pay at weekends, all of the other issues have resolved to the satisfaction of all parties although it is possible that there will be a net unplanned increase in the cost for all employers.<br><br>Junior doctors are issued with new contracts when they move to different hospitals as part of their training and so from later this year there is an expectation, which will be enforced by the Deaneries, that only new contract terms are used. Trusts will not be expected to move away from the contract terms recommended by the Department of Health.<br><br>The BMA have announced further strike action on 9 March to 11 March, 6 April to 8 April and 26 April to 28 April 2016. The junior doctors will support emergency services only on these dates.<br><br>**Sustainability and Transformation Plans**<br><br>The Frimley Health footprint has been agreed by NHS England as a planning unit to devise a Sustainability and Transformation Plan which every system has to deliver. Normally the recommended size is a 2 million population but given the complexities of the Frimley System, NHSE support has been secured for now to undertake this work. It is expected that all CCGs, Local Authorities and Providers will participate with the objective of delivering the 5 year Forward View with a focus on health and well-being, care and quality and finance and efficiency. This also provides better opportunity to align the Vanguard, Integrated Hubs, Vision of Care and Better Care Fund initiatives across the Frimley System.<br><br>It is expected that all leaders of organisations will work together to engage with the public and staff to develop a single local plan over the coming months.<br><br>Some elements of the plan will need to relate across a larger footprint and it is unclear at this stage how a Frimley Health Plan will interface with separate plans for Hants, Berks, Bucks and Surrey. NHS England and NHS Improvement will be reviewing plans later in the spring and holding systems to account for delivery. |

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| | **CQUIN**<br><br>FHFT has achieved 100% of the national CQUIN requirements for Quarters 1,2 and 3. Quarter 4 will be challenging due to the nationally set targets of 90% for AKI and Sepsis although significant improvements should have been made across all sites.<br><br>FHFT has also achieved 100% of the local CQUIN programme for Quarters 1,2 and 3. The local CQUIN programme has focused on improving the quality of our discharge summaries, identification and support of unpaid carers, improving the relationships with local care homes and reducing waits for care home assessments. FHFT have also focused on identifying frailty to ensure on-going care and support is tailored to meet the complex needs of this patient population.<br><br>The success to date will have improved care for patients and has strengthened relations with primary care providers. It is expected the CQUIN programme will achieve approximately £11m of income for FHFT. |
| Recommendation: | The Board are asked to note the report. |

Frimley Health NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**
**4 March 2016**

| | |
|---|---|
| Report Title: | **CQC Inspection Report Wexham Park October 2015** |
| Agenda Number: | 7. |
| Report Purpose: | To brief the Board on the outcome of the inspection and sign off the action plan. |
| Executive Lead: | Andrew Morris, Chief Executive |

In February 2014 the CQC inspected Heatherwood & Wexham Park and Heatherwood was rated as "Good" but unfortunately, Wexham was rated as "Inadequate" and the Trust was subsequently put into special measures as a consequence. In October 2014 Frimley Park and Heatherwood & Wexham Park merged and the CQC dropped the special measures status and issued eight requirement notices to Frimley Health. At the time of the acquisition the CQC agreed that Wexham would be re-inspected after one year to determine the level of improvement achieved.

The CQC used a team of 52 people to inspect Wexham Park during the 13 – 16 October. The inspection team was chaired by Heidi Smoult – Deputy Chief Inspector of Hospitals – who had been the lead inspector in February 2014. The attached report was published on 2 February 2016 and Wexham Park was awarded an overall rating of "Good". The table below shows the rating by service and domain.

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Good | Good | Good | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding |
| Medical care | Good | Good | Good | Good | Good | Good |
| Surgery | Good | Good | Good | Good | ☆ Outstanding | Good |
| Critical care | Good | Good | ☆ Outstanding | Good | ☆ Outstanding | ☆ Outstanding |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | ☆ Outstanding | Good |

| | |
|---|---|
| | Only a handful of Trusts have one from “Inadequate” to “Good” on a subsequent inspection. Also the CQC did not rate a single service below Good which is exceptional. Nearly 60% of all Trusts are rated as “Requires Improvement” or less and so the staff at Wexham have worked tirelessly to improve the offering to the local community to good effect.<br><br>Also attached is the post inspection action plan. The Trust is expected to remedy all the points highlighted within 6 months. A separate report was issued for chemotherapy service on the King Edward site. The Trust has been issued with a requirement notice for poor controls of temperatures for chemotherapy drugs and one of the toilets did not have an emergency call bell system. These 2 items were actioned within a week of receiving the report.<br><br>Frimley Health FT has the best rating of any multisite organisation:<br><br>Frimley Park Hospital – Outstanding<br>Wexham Park Hospital – Good<br>Heatherwood Hospital – Good |
| Recommendation:<br><br>The Board is asked to support the action plan and a further update on this will be submitted in 6 months to confirm that all the actions have been attended to. | |

Care Quality Commission

# Frimley Health NHS Foundation Trust

# Wexham Park Hospital

## Quality Report

Wexham Park Hospitals
NHS Foundation Trust
Wexham Street
Wexham
Slough
SL2 4HL
Tel:01753 633000
Website:www.frimleyhealth.nhs.uk

Date of inspection visit: 13, 14 and 15 October 2015.
We also carried out three unannounced visits, on the 21 and 22 October and 31 October 2015.
Date of publication: 02/02/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

| | |
|---|---|
| **Overall rating for this hospital** | **Good** |
| Urgent and emergency services | Outstanding |
| Medical care (including older people's care) | Good |
| Surgery | Good |
| Critical care | Outstanding |
| Maternity and gynaecology | Good |
| Services for children and young people | Good |
| End of life care | Good |
| Outpatients and diagnostic imaging | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Wexham Park Hospital is a district general hospital serving a population of around 465,000 people with approximately 3,400 staff and around 700 beds. Since October 2014 it has formed part of Frimley Health NHS Foundation Trust (FT), when Frimley Health NHS FT acquired Heatherwood and Wexham Park Hospital. Wexham Park Hospital was the main acute site of the previous trust.

The previous Heatherwood and Wexham Park NHS FT was inspected by CQC in February 2014. The trust was rated as Inadequate. At that time 3 of the 8 core services at Wexham Park were individually rated as inadequate (Medicine, Surgery and Maternity) with a further 3 core services being rated as Requires Improvement (Urgent and Emergency Care, End of Life Care and Outpatients). Critical Care and Children's and Young People's services were the only services to be rated as good at that time. Consequently Heatherwood and Wexham Park NHS FT was placed in special measures.

Following the acquisition by Frimley Park special measures were lifted. This was because Frimley Park NHS FT had been rated as Outstanding in September 2014. This was the first trust in England to be rated as Outstanding with 5 of the 8 core services being individually rated as Outstanding and 3 of the 5 key questions being rated as Outstanding including the key question relating to the trust being Well Led. However, following the acquisition a number of requirement notices related to the Wexham Park location were issued in respect of aspects of care that had been of particular concern.

CQC reinspected the Wexham Park location in October 2015, just over a year after the acquisition and formation of Frimley Health NHS FT. This was a comprehensive inspection of the hospital/location to assess the current quality and safety of care. We did not reinspect the Heatherwood location as this had been rated as Good following the inspection in February 2014.

This report demonstrates that remarkable progress has been made since our previous inspection. Indeed this is undoubtedly the most impressive example of improvement that CQC has observed since our new approach to inspection started in September 2013.

All the external stakeholders we spoke with as part of this inspection were very positive about the progress that has been made over the past year. These included Monitor, NHS England, local CCGs, local HealthWatch and the Health Overview and Scrutiny Committee. We heard from staff working at Wexham Park that the culture in the hospital had improved markedly with a greater degree of openness at all levels. Governance had been completely revised, major improvements had been made with regard to handling of complaints and incident reporting. The number of student nurses who have opted to stay at Wexham Park Hospital following qualification has increased substantially over the past year.

Staff were much more positive about Wexham Park as a place to work than previously and a much higher proportion of staff would now recommend the hospital as a place to be treated. Key measures of performance such as the 4 hour A&E target, cancer waiting times targets and referral to treatment targets have improved markedly.

In relation to individual services, both the Urgent & Emergency Care service and Critical Care have now been rated as Outstanding with all other services being rated as Good. Three services were rated as Outstanding for being well led. This, together with the overall leadership at Wexham Park Hospital has resulted in the Well Led key question being rated as Outstanding for this location. This has been achieved by a team of experienced clinical leaders, mainly but not exclusively from Frimley Park, working with Wexham Park Hospital staff to deliver much better care for patients.

**Our key findings were as follows:**

**Safe**

# Summary of findings

There were effective and robust systems and protocols in place to protect patients from harm, and staff contributed positively to an incident-reporting culture that provided opportunities for continual learning. We found learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us in detail about improvements in practice that had occurred as a result.

A culture of openness was found in the Trust. However, there was room for improvement with the policy and application of policy around Duty of Candour.

Staff contributed to the NHS Safety Thermometer programme. Information was collected on a weekly basis and clear, easy-to-read information was displayed for staff, patients and visitors across the hospital site.

The hospital was clean. However, the auditing of cleaning was not being managed in line with best practice guidance.

Medicines management had improved since our last inspection. Regular medicines audits took place; such as audits of the management of controlled drugs and antibiotic prescribing. Actions were taken where issues were identified such as a change in the antibiotic prescribing policy.

Staff attendance at mandatory training had improved since our last inspection. Mandatory training was monitored and all staff expected to attend on an annual basis. Staff told us that there was less 'e-learning' since joining with Frimley Heath NHS Trust and the quality of training had improved. They also told us they now received relevant training specific to their role.

Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks, including portable appliance testing (PAT).

The trust had identified that improvements in the management of deteriorating patients was a priority. A lead nurse for the management of deteriorating patients had recently been appointed and a work stream was in place to drive improvement across the trust. Actions included ensuring the availability of the resuscitation team, training for newly qualified staff and a review of early warning systems used across the NHS.

At this inspection we found nurse staffing had improved although there were still a number of staff vacancies. Providing safe staffing was an acknowledged risk for the hospital and there were appropriate action plans in place to monitor and address the risk on a daily basis.

**Effective**

Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations.

National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) and CRAB (Copeland's Risk Adjusted Barometer) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.

There was a consistent and standardised approach to multidisciplinary meetings and morbidity and mortality meetings trust-wide. The trust told us that attendance was good and learning identified with monthly updates and reports to the Trust's Quality Committee. The trust had considered the results from national reviews such as the review into mortality and morbidity, and action had been taken to implement the findings and recommendations.

The trust had a range of clinical governance groups who were responsible for reviewing best practice guidelines and changes to legislation. Audits took place against national guidelines with changes to practice shared where appropriate.

# Summary of findings

The trust identified that not all policies and procedures at Wexham Park Hospital were in date or reflected current best practice. An action plan was in place to prioritise the policies to be updated and the resources required to undertake this. In the meantime the chiefs of service were reviewing policies and procedures to make sure patients were safeguarded. Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff.

### Caring

The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. We also received positive feedback from patients who had received care at Wexham Park Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

During our inspection we observed patients being treated in a professional and considerate manner by staff. All the staff we spoke with were enthusiastic about the service they provided and gave examples of 'going the extra mile' to ensure patients received good-quality care that they would want their own families to receive.

### Responsive

There had been an improvement in patient flow through all departments of the hospital. The Emergency Department (ED) had re-designed the service to improve patient flow through the department. Wards and departments across all directorates had also made improvements in patient flow through the hospital. Improvements were reflected in data throughout the hospital and the in the ED despite an increased number of people accessing the service the proportion of patients being seen within four hours had improved from 93% to 95% (meeting the national standard) and was being sustained consistently.

At the last inspection, we found complaints were not dealt with in a timely fashion and a backlog had developed. These had now been dealt with and any new complaints were being managed more effectively. Specialist staff were now managing complaints centrally.

We heard of the positive initiatives in place to support patients living with dementia. Dementia Leads were reviewing the care of patients living with dementia across all the trust's sites against the trust's Dementia Strategy.

Staff had access to resource folders for patients admitted with special needs such as a learning disability. There was an email 'in-box' for staff to raise any queries, referrals or concerns.

### Well led

Following the acquisition of Wexham Park Hospital by Frimley Health NHS Foundation Trust in 2014, the trust's values, vision and strategic plan were reviewed and revised.

At this inspection we spoke with a positive and ambitious workforce. Staff told us that they felt valued and felt able to put excellent patient care and experience at the heart of their work.

Staff across the hospital told us how the trust's values were now embedded throughout their directorates and were monitored through local work and the appraisal system.

Since the last inspection the executive team had taken action to ensure they were visible on the wards and in the departments and ensured they engaged with front line staff, listening to feedback and acting promptly on any concerns raised. Senior staff walkabouts were undertaken to engage with staff and obtain direct feedback.

The trust implemented a new governance and committee structure with Board level quality assurance informed by new quality committees. Clinical governance was now embedded at local level with structured standard agendas complete with minutes and action logs. The local groups reported to the quality committee and to the Board via the Trust's Clinical Governance Committee.

# Summary of findings

Since the last inspection the trust had established a clear set of values together with the expected standards of behaviour expected from all staff employed by the trust. Direct action had been taken to address the behaviour of individuals who did not demonstrate the professional standards of behaviour expected.

The quarterly Family and Friends Test included additional questions regarding values and leadership. The most recent results (April 2014 to September 2015) showed improvements in staff recommending the Trust as a place to work up 17% to 57% and in staff recommending the trust as a place to have treatment up 25% to 69%.

New central directorates had been established to manage complaints, patient safety and quality assurance.

The Family and Friends Test had been expanded to include questions, which gave a baseline on the patient safety culture within the trust.

A Patient Safety Committee had been established at Wexham Park Hospital and met monthly to share outcomes and take pro-active actions taken to improve safety.

**We saw several areas of outstanding practice including:**

- Leadership in the Trust had inspired a culture shift since our last inspection that was evident across the hospital in all of the staff groups that we spoke with. Staff were proud to work in the hospital, and were committed to delivering care that met with the trusts values and vision.
- The improvements to patient flow through the ED meant that patients being seen within four hours had improved from 93% to 95% (meeting the national standard) and was being sustained consistently despite an increased number of people accessing the service.
- In critical care staff showed considerable innovation in meeting the individual needs of patients under exceptional circumstances.
- Staff engagement throughout outpatients and diagnostic imaging departments was outstanding. All staff were working towards common values, both clinicians, administrative and support staff, at all levels.
- The achievement of the radiology department to reduce and maintain their waiting times, in view of reduced staffing levels and equipment issues showed an outstanding commitment to improve patient experience.
- The improved booking centre processes in outpatients and radiology which involved multidisciplinary team members and ensured patients got the right appointment at the right time.
- Medical records were available more than 99% of the time, over the past 12 months.
- The roles of the five practice and development midwives were split between 50% clinical work and 50% administration and teaching workshops. One midwife worked every day in the labour ward to provide on the spot guidance and support to midwives.
- We observed outstanding prompt, appropriate and sensitive care and treatment provided for a woman in the labour ward who had complex and sensitive needs. Staff adhered to the comprehensive care plan they had developed to ensure the woman did not experience unnecessary distress.
- The hospital had comprehensive guidelines for staff in regards to female genital mutilation (FGM). The trust's safeguarding children annual report 2014/15 recorded that the identification of FGM had been an area of development for the trust. The trust had a policy of addressing FGM when booking women for maternity care.
- The hospital had a Deputy Director for Clinical Education who had developed a comprehensive preceptorship programme for newly qualified nurses. This was a structured period of transition for the newly qualified nurses when they started their employment at the hospital. We viewed comments from newly qualified nurses' evaluation forms from their learning and found these to be consistently positive.
- The matron on children and young people's ward had received a trust recognition award for leadership.
- A senior nurse in critical care had been seconded into a research post for the year before returning to full time clinical duties. They had contributed to the application of the good clinical practice (GCP) guidance of the NIHR Clinical Research Network, which had been used to prepare a research working book for other nurses to use as a benchmark

for research processes, from screening to final data analysis. The research was quality assessed by Monitor through site visits to check that research protocols adhered to gold standard clinical and ethical requirements. The lead research nurse had attended a GCP training course and had successfully been certified against national standards including ethics, legislation and application of the Mental Capacity Act (2005).

- One of the key research projects, VANISH (Vasopressin versus Noradrenaline as Initial therapy in Septic shock), had resulted in specialised one-to-one training packages for staff and an invitation for staff to present their findings at the European Intensive Care Society Conference in 2015. The study had looked at the avoidance of acute kidney injury through the use of steroids with inotropes and the results were presented to staff in the unit on completion of the study. Other projects included a study of the effectiveness of emergency laparotomies and a study of the translocation of bacteria in abdominal sepsis to consider specific antibiotic therapy. The impact on nurses had been very positive and for three consecutive years, research-active staff had attended the European Intensive Care Society Meeting as recognition of their efforts towards establishing an active programme of testing best practice and treatment.

**However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must:**

- The cleanliness of the hospital must be audited in line with standards set out in the national specifications for cleanliness in the NHS (NSC). This includes the correct classification of high risk and very high risk areas and the frequency of auditing in these areas. Audit processes should include a re-audit where areas are found to be less than 100% compliant. If the hospital chooses not to audit to NSC standards they must provide evidence of an equally robust auditing programme.
- Ensure that their policy around Candour (DoC) includes incidents resulting in 'psychological harm'. The provider must also ensure the policy is followed when managing incidents that come under this regulation.
- Continue with its delivery and the risk priorities associated with the backlog program. Fire risks associated with backlog need to be addressed as a priority.
- Improve Estates governance and ensure that up to date and approved policies and standard operating procedures (SOP's) are in place.
- Ensure that monitoring of weekly medicine stock checks in critical care is consistently applied and must ensure that the system in place to make sure out of date medicine is disposed of is audited.
- Ensure that resuscitation equipment is always checked according to the trust policy. The auditing system must include a visual check of the expiry dates of batteries
- Cleaning and storage materials in critical care must be stored in locked facilities and the lock for the cleaning cupboard must be replaced.
- Recruit to the three vacant consultant posts in ED. Although consultant cover in ED had improved since our last inspection the department still fell short of national standards.
- Ensure that all oxygen cylinders have an expiry date displayed, and system in place for staff to check that cylinders are within date.
- Continue to improve staffing recruitment and retention.

**In addition the trust should:**

- Ensure all staff in outpatients have development opportunities and training as agreed in their personal development plans.
- Ensure that regular and routine checks are made of the temperature of medication fridges.
- Consider plans for an additional CT scanner and integrated x-ray within the new emergency centre development planned for 2016.
- Improve pharmacy support for the emergency department and the decision unit (EDDU) in particular.
- Explore an effective means of explaining to patients why they have to wait to be treated in the ED.
- Consider testing the major incident plan which had recently been re-written.

# Summary of findings

- Consider the size and organisation of paper health records.
- Ensure the audit trail of medications delivered to wards is completed including the signature of the staff member receiving the medications on the ward.
- Consider the safety of Aria e prescribing system which is not available to staff in the ED and the patient risks associated with this.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating |
|---|---|
| Urgent and emergency services | Outstanding ☆ |

### Why have we given this rating?

Overall we rated the emergency service at Wexham Park hospital as 'Outstanding' because:
Since our last inspection in 2014, a new leadership structure had been developed. Consultant medical staff now provided leadership for some aspects of the service, such as clinical safety and patient experience, clinical governance, education and training. There had also been changes to the senior nursing team with the appointment of matrons who now oversaw the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for. We found these changes had resulted in sustained improvements in the quality of care patients received.
At our last inspection we were concerned that some patients spent a long time in the ED waiting to be seen. The service had difficulty meeting the national quality standard for 95% of patients being seen in less than four hours. At this inspection, we found the trust had met the four hour quality standard since February 2015. Patients were assessed quickly and the service had met the national quality standard for 95% of patients being seen in less than four hours since February 2015.
Consultant medical staff provided effective leadership of the service such as clinical safety and patient experience, clinical governance, education and training. Senior nurses took responsibility for the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for.
The service was well co-ordinated through board rounds held four times a day and clinical practice was audited against the standards set by the College of Emergency Medicine (CEM). Guidelines were accessible and followed by staff.
The ED audited clinical practice against the standards set by the College of Emergency Medicine (CEM). The college of emergency medicine is a body which sets national standards for emergency services. The department was also part of the Thames Valley Trauma Network, which aimed to develop high-quality trauma care across all the hospitals in the area. This involves the ED service being reviewed against a set of national quality standards and undergoing a quality review by clinicians providing similar services in other hospitals.

# Summary of findings

The ED had a system in place for monitoring changes in a patient's condition. The Detection of Deterioration (EDOD) scoring system was used when patients were first assessed and to monitor their condition during their stay in the ED. Similar systems were in place for both adults and children. Staff monitored each patient's condition and were able to reduce the risk of unsafe care if they deteriorated.

When we last visited the hospital we found the number of patients waiting between four and 12 hours and longer than 12 hours for admission was much worse than the England average. At this inspection we found that the number of people waiting longer than 12 hours for admission had reduced steadily from 23 in April 2015 to five in June 2015. This reduction may reflect a difference between the seasons with fewer admissions required during the summer months. However, the hospital had also been working on a range of ways of improving the movement of patients from the ED to other departments which had contributed to this reduction.

At our previous inspection we found that patients who were waiting a long time for admission did not have the condition of their skin checked and were not offered anything to eat or drink, both of which are good practice. At this inspection we found staff had improved the care provided and now monitored the condition of patient's skin and provided food and drink to those waiting.

Staff delivered care based on best practice national guidelines. At our last inspection we found staff had good knowledge about the guidelines and audits in place, but were less clear about how improvements were going to be implemented. At this inspection we found that the hospital had strengthened the structures for overseeing the implementation of guidelines and there were effective, clear written information accessible on the computer for all staff working in the department.

Staff spoke positively about the considerable changes that had taken place over the last 12 months and the pace at which this had been achieved. They told us the leadership of the department provided clarity about the vision for the service and senior medical and nursing staff provided support and direction. Consultant medical staff had highly visible leadership responsibilities for improving the quality of service

which staff believed was making a positive difference. Staff told us they felt more motivated, supported and energised. They were proud to work in the ED because the leadership and culture had improved.
The ED had worked with other departments to reduce the length of time patients waited to be admitted. Three additional consultants had been appointed, which enabled senior staff to have a greater presence in overseeing the work of the department. Senior nursing staff also spent more time supervising the quality of patient care.
However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:
The need to improve access to CT scanning. There is currently only one scanner on site. Patients were diverted to another hospital when the CT scanner was out of action. the trust planned to provide a second scanner when the new emergency department is built however the Trust should seek to ensure all patients requiring a CT scan were able to receive one, at the earliest opportunity.
Pharmacy support for the department was limited to 16 hours a week. Patients in emergency department decision unit (EDDU) needed their medicines reviewed before they could return home the lack of pharmacy support sometimes led to delays in patients being discharged.
A new major incident plan had been developed but not all staff were aware of it. The plan had not yet been rehearsed or tested but a simulation was planned.

**Medical care (including older people's care)**

**Good**

Overall we rated medical care (including elderly care) at Wexham Park Hospital 'Good' because:
We found medical care at the hospital was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The hospital was able to demonstrate that it mostly met national quality indicators.
Patients' medical outcomes were monitored and reviewed through formal national and local audits. Consultants led on patient care and there were

# Summary of findings

arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety.

We found that the hospital was working towards offering a full seven-day service. Although some medical patients were treated in other areas of the hospital when beds were not available, systems had been put in place to ensure the consistent quality of their care. Staff responded to individual patient needs for those living with dementia.

The hospital had systems in place to allow patients to feedback their experience of care on the medical wards. The results of the surveys indicated that the department provided excellent, compassionate care by friendly and approachable staff. Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. Complaints processes had been improved since our last inspection. Complaints were acknowledged, investigated and responded to appropriately.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

We found some paper health records to be large in size and documentation was hard to locate in these records easily.

The electronic prescribing system used for patients requiring chemotherapy could not be accessed by staff working in Emergency Department (ED). Although staff had put in measures to mitigate this risk the trust may wish to reassess the risks associated with these measures.

There was an overdependence on agency staff to support permanent staff to ensure safe staffing levels during the delivery of chemotherapy.

**Surgery** **Good**

Overall we rated surgical services at Wexham Park Hospital as 'Good'. This was because:

# Summary of findings

The majority of issues identified in the previous report had been addressed. The trust had action plans for areas of concern that remained, such as staffing. Staff continuously monitored these plans and took appropriate actions in a timely manner.

We found that leadership in all areas had improved. Senior staff were visible, available and supportive to all staff. We found that improvements throughout the surgical division meant that patients experienced safe, effective and appropriate care and treatment that met their individual needs and protected their rights. Staff provided care that was compassionate and all patients were treated with respect and dignity. Patients had their individual risks identified, monitored and managed. There were systems to regularly monitor and review the quality of service provided.

Staff were competent and knowledgeable about their specialties on both the surgical wards and in the theatre units. Mandatory training was generally up to date with further staff training and development available and encouraged.

Outcomes for patients were good and the surgical departments followed national guidelines. The clinical environments, including the equipment available, were clean and well maintained. Departments undertook frequent audits such as environmental, theatre checklist, infection control and hand hygiene. Clinical governance teams analysed the audits and fed the results back to staff. Where risks were identified there were action plans to resolve or manage them in a timely fashion.

Incidents and complaints were investigated and handled in line with trust policy. There were systems to feedback to staff any learning from incidents and complaints.

The trust had recognised that improvements were needed to address the culture within the surgical division and had taken robust action to address the bullying issues. Staff were enthusiastic about the initiatives taken to address the concerns raised at the last inspection and were passionate about the quality of care they delivered.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

# Summary of findings

There was a degree of underreporting of incidents. The trust was aware of this issue and had strengthened governance systems and improved training and development in reporting and managing incidents and complaints.
Although we noted an improvement in medicine management, there were still some practices that did not meet current best practice or comply with national guidelines. Issues included insufficient monitoring of temperatures and security.

## Critical care

**Outstanding** 

Overall we rated the critical care (CCU) at Wexham Park Hospital as 'outstanding' this was because:
We found significant areas of good practice through our review of clinical audits, staff training, patient notes, clinical outcomes and other indicators such as an exemplary programme to promote independence and person-centred care. Leadership in the unit was coherent, robust and respected by staff. This leadership contributed to a team that continually challenged existing practice to identify new and improved ways of working. Innovation was very much part of the culture in the unit and staff spoke positively about the development opportunities available to them as a result.
Clinical practice was benchmarked against national guidance from organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and staff used it to evaluate and improve their practice. For example, an extensive programme of audits was used to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC). They then used the national audit results alongside local studies to inform the planning of staff study days. The CCU team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure best care for patients. An established critical care outreach team supported patients across the hospital and provided bereavement and emotional support.
The CCU appeared clean, hygienic and well maintained. Staff demonstrated good infection control practices but there was room for improvement in some areas of housekeeping. Equipment was serviced regularly and staff were competent in its use with regular training

updates. We found one area of non-compliance with the trust's medication management policy but there were safeguards in place to ensure that this would not affect patient safety.

A robust incident reporting system was in place that staff confidently used to investigate incidents and errors. There was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice. These measures contributed to an environment in which safety was prioritised and patients received individualised care.

We observed numerous instances of significant commitment to personalised care. Staff were competent, passionate and driven, and their efforts included supporting a patient to return home safely to their garden during an extended CCU stay and a programme to promote independence in patient recovery in the middle of their recovery. Staff were active in clinical research and were supported in this by a senior team of nurses and doctors who understood the need for continued innovation in care and treatment. One relative told us, "I am overwhelmed by the attention of all of the people looking after [relative]."

Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with Royal College of Nursing (RCN) guidance. The use of agency staff was consistently below the maximum acceptable level set by the trust and temporary staff underwent stringent induction and background checks before working on the unit. Without exception staff told us they were supported and valued by the senior team and they felt proud to work in the unit.

At our last inspection of Wexham Park Hospital, we found critical care services to be good and responsiveness to require improvement. This was because admissions and discharges were often delayed and patients were sometimes transferred out of hours because of a lack of capacity elsewhere in the hospital. At this inspection we found a significant and sustained improvement in these areas, with an acute commitment from the senior team to improve the unit's responsiveness to patient needs that had been highly successful. In areas that we previously found to be good, staff had worked hard to build on their existing practice and explore innovation in patient care and treatment.

# Summary of findings

## Maternity and gynaecology

**Good**

Overall we rated maternity and gynaecology services at Wexham Park Hospital as 'good'. This was because:
At our last inspection carried out in February 2014 we found the maternity and gynaecology services to be inadequate. This was because of failure to report incidents and reliance on bank and agency staff to maintain the services. Governance arrangements were poor with inadequate systems for monitoring staff performance and dealing with an inappropriate staff culture. We evidenced that the majority of issues identified in the previous report had been identified and addressed.
Patients were protected from the risk of avoidable harm and, when concerns were identified staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary, actions were taken to prevent recurrences. Medical, midwifery and nursing staff provided safe care; staffing levels were in line with national averages and were regularly reviewed.
Staff delivered evidence-based care and treatment and followed NHS England and the National Institute for Health and Care Excellence (NICE) national guidelines. There was multidisciplinary working that promoted integral care. The audit programme monitored whether staff followed guidelines and good practice standards. The previous high caesarean section rate was in line with the national average. Staff were caring and thoughtful, and treated women with respect. Patients' confidentiality and privacy were protected. All the patients and relatives we spoke with gave positive feedback about their care and how staff treated them. Women and their partners felt involved with their care and appropriate explanations were given to them. Policies and procedures were available on the hospital's intranet for all staff to access. Appropriate arrangements were in place for patients who could not make informed decisions about their care. Systems were in place to support patients who had a learning disability. Complaints were dealt with effectively and improvements made where necessary. There had been a decrease in the number of complaints made since the previous inspection.
There were established local governance arrangements and risk management identified risks to patients and service delivery through the risk reporting process. This is a process for dealing with risks, actions taken to

minimise them and recognising those that required reporting to NHS England. Staff demonstrated a strong desire to develop the services and efforts had been made to gain the views of patients and the public. The widespread poor culture found during the previous inspection had almost gone. Senior managers were working towards eliminating poor practices. Many improvements had been made and staff had an open and motivated attitude that had strengthened the culture throughout. Senior managers had developed a plan to sustain the improvements and continue improving the quality of the services.

## Services for children and young people

**Good**

Overall we rated services for children and young people at Wexham Park Hospital 'Good' because:
The treatment and care needs of children and infants were assessed and planned from referral to discharge, taking into account their individual needs. The health and wellbeing of children, young people and infants was monitored using recognised assessment tools. Arrangements were in place for looking after vulnerable children. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs as and when required.
Children who spoke with us said that the staff' were kind and caring and that they received information that helped them understand what treatment and care they were receiving. Staff helped children and young people and those close to them to cope emotionally with their care and treatment. Comprehensive safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding. The service had systems in place to ensure that incidents were reported and investigated appropriately.
Children and young people's services were well-led by a very enthusiastic and committed staff team. The leadership, governance and culture promoted the delivery of high quality child-centred care. There was a clear statement of vision and values, driven by quality and safety, with defined objectives. Staff were aware of best practice guidance for the safe and effective care of children and infants. The service had experienced nursing staff shortages, but were actively recruiting nurses by advertising the vacancies.

## End of life care

**Good**

Overall we rated the EOLC services at Wexham Park Hospital as 'good' this was because:

# Summary of findings

National guidance determines precisely what end of life care (EOLC) should look like for adults diagnosed with a life limiting condition in all care settings. EOLC is defined as a patient with less than 12 months to live no matter what the diagnosis.

Overall we found the EOLC service provided by Wexham Park Hospital was good. The duty of the inspection was to determine if the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. The hospital provided mandatory EOLC training for staff which was attended, a current End of Life Care Policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

Staff at Wexham Park Hospital provided focused care for dying and deceased patients and their relatives. Facilities were provided for relatives of patients and patient's cultural, religious and spiritual needs were respected. Further supplies of syringe drivers were purchased to enable a dying patient to receive prompt, adequate and appropriate medication.

The palliative care team had a high level of evidence based specialist knowledge. They worked well with the local hospice and other departments involved in providing EOLC. The team were well thought of throughout the hospital. They supported, trained and gave advice to other staff.

There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. Through education and acknowledgement of national guidance the number of referrals to the palliative care team had increased since the last inspection and these referrals were seen and acted upon within 24 hours.

At our last inspection of Wexham Park Hospital we found the EOLC service to require improvement. This was because the service relied on the drive and vision of the EOLC team and not through any trust wide strategy. EOLC did not appear to be a priority for the trust.

Since the hospital's acquisition by Frimley Health NHS Foundation Trust the service had board representation and a dedicated clinical lead. This had resulted in a well led trust wide service that had a clear vision and strategy.

# Summary of findings

## Outpatients and diagnostic imaging

**Good**

Overall we rated the outpatients and diagnostic imaging departments at Wexham Park Hospital as 'Good' this was because:
The hospital consistently met waiting and treatment times in line with national standards. Professional staff treated patients with kindness, dignity and respect. The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.
The booking centres had processes to ensure patients received appointments within the appropriate timeframe. There were fail-safes in place and medical staff assisted management if required. Medical record management enabled clinicians in outpatients to have access to patients' records more than 99% of the time.
The radiology department had worked to reduce waiting times in the past year,
Staff were competent , professional and treated patients with dignity and respect. The outpatient and diagnostic imaging department appeared clean and well maintained. Staff demonstrated good infection control practices . Equipment was serviced and maintained regularly.
Every member of every team contributed positively to patient care. All staff shared the vision and values of the hospital and good leadership was visible at all levels. Staff worked hard to deliver improvements in their departments. They were proud of their achievements and had the vision and energy to continue with improvements and develop services further.

# Wexham Park Hospital

## Detailed findings

**Services we looked at**

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

# Detailed findings

## Contents



## Background to Wexham Park Hospital

Wexham Park Hospital is part of Frimley Health NHS Foundation Trust and provides services to a large and diverse population of more than 465,000. The area it covers includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor. The hospital has approximately 3,405 staff and a total of 706 beds.

The Hospitals catchment area population includes a significant proportion ethnic minority groups and 30 languages are spoken in the area covered by the trust. The most common (excluding English) include Hindi, Polish, Urdu, Somali, Romanian and Punjabi.

The Hospital was previously managed by another Trust and had been placed in special measures after being inspected on 1st May 2014. Following this inspection the Hospital was acquired by Frimley Health NHS Foundation Trust and its special measures were lifted and replaced by a number of requirement notices. The Care Quality have been closely monitoring the Trusts improvement strategy since acquisition.

The trust had a long history of turbulence prior to acquisition with a high turnover of senior leadership which had resulted in poor outcomes in previous CQC inspections.

## Our inspection team

**Chair:** Heidi Smoult – Deputy Chief Inspector of Hospitals Care Quality Commission

**Head of Hospital Inspections:** Alan Thorne, Care Quality Commission

The team of 52 included: CQC Inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics; an anaesthetist; physicians and a junior doctor; midwives; surgical, medical, paediatric, board level, critical care and palliative care nurses'; imaging specialists; estates and facilities directors and experts by experience.

## How we carried out this inspection

To understand patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

# Detailed findings

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following eight core services at the Wexham Park Hospital:

• Accident and emergency

• Medical care (including older people's care)

• Surgery

• Critical care

• Maternity and gynaecology

• Services for children and young people

• End of life care

• Outpatients and diagnostic imaging

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

An inspector from the CQC facilitated a stall in the entrance to the hospital during the inspection where people stopped and shared their views and experiences of Wexham Park Hospital with us. We also spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us.

We carried out the announced inspection visit between 13, 14 and 15 October 2015. We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, staff side representatives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also carried out three unannounced visits, on the 21 and 22 October and 31 October 2015.

## Facts and data about Wexham Park Hospital

### Local demographics

Wexham Park Hospital provides hospital services to a large and diverse population of more than 450,000 which includes Maidenhead, Slough, South Buckinghamshire and Windsor.

There are approximately 30 languages spoken in the area, the top six of which (excluding English) are Hindi, Polish, Urdu, Somali, Romanian and Punjabi.

On the whole, the general health of people in the area is better than the England average. Priorities for the region include; childhood obesity, cardiovascular disease, early detection of dementia and falls prevention, early diagnosis of cancers including prostate, skin and colorectal and prevention and early detection of long-term conditions, heart disease and stroke.

Deprivation: The Royal Borough of Windsor and Maidenhead is a Royal Borough of Berkshire, in South East England. The 2010 Indices of Deprivation showed that Windsor and Maidenhead UA was the 303rd most deprived local authority (out of 326 local authorities, with 1st being the most deprived). Slough was ranked at 93 and South Bucks at 298.

### Activity

Between 2014 and 2015 the trust facilitated:

- 80,698 inpatient admissions
- 384,044 outpatient attendances
- 108,856 Accident and Emergency attendances

### Context

- Serves a population of approximately 450,000
- Employs around 3,405 staff

# Detailed findings

### Intelligent monitoring – Safe

- 1 never event at the hospital in January 2015.
- There has been 45 serious incidents reported mainly relating to delayed diagnosis and slips/trips and falls.
- The number of incidents reported per 100 admissions places the hospital better than the England average.
- 94% of all incidents reported were low and no harm.
- Harm Free Care Indicators: Eight of the 31 wards listed have an average percentage below 95%,14 ward areas scored 100% in August 2015.

### Intelligent monitoring - Effective

- Risk - SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator Jul-14 Sep-14
- Turnover rate (leavers) for Nursing and Midwifery staff Jan-14 Dec-14
- Ratio of all midwifery staff to births Jan-14 Dec-14

### Intelligent monitoring – Caring

- The trust were rated in the middle 60% for 17 indicators and within the bottom 20% for 20 of the indicators in the Cancer Patient Experience Survey 2013/14
- Better than the England Average for Patient-led assessments of the Care Environment (PLACE) for 2014.

### Intelligent monitoring – Responsive

- The trust's bed occupancy has been above the national average for the time period with no data from Q2 2014/15

### Intelligent monitoring – Well Led

- Of the 31 indicators within the NHS Staff Survey, the trust has 13 negative findings, and 1 positive findings and 17 findings within expectations. Notably 20 of the 29 indicators previously used in 2013 have seen a lower score in 2014

## Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Good | Good | Good | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding |
| Medical care | Good | Good | Good | Good | Good | Good |
| Surgery | Good | Good | Good | Good | ☆ Outstanding | Good |
| Critical care | Good | Good | ☆ Outstanding | Good | ☆ Outstanding | ☆ Outstanding |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Good | Good | Good |
| **Overall** | Good | Good | Good | Good | ☆ Outstanding | Good |

# Detailed findings

## Notes

On this inspection we looked in detail at how the hospital was implementing Duty of Candour (DoC) regulations. A culture of openness was found in the Trust. There was general awareness of the need to be open amongst staff we spoke with. Senior management had led the review of a number of specific incidents and had shared the findings.

A DoC policy and procedure was in place, although formally agreed only shortly before the inspection. This covered the necessary steps but did not encompass incidents resulting in 'psychological harm'. This was also omitted from prompts within the Datix system, where summary information was recorded.

Whilst two audits had been carried out, the results of the first being available for review during inspection, the Trust's level of compliance and implementation of steps in connection with the duty was not monitored by the Board.

The Trust's quarter 1 audit of their implementation of the duty showed that, in most of the 21 cases reviewed, feedback had been given to people when they had been, or could be, adversely affected by a notifiable safety incident. However, there were no records of a written apology to any of these 21 people and records about whether this was given verbally were patchy.

A review of six further incidents was carried out by the inspector with the direct help of Trust staff. Staff agreed that four of the six records did not comply with the duty and the right volume of the patients' notes was not easily located for the remaining two. Two did not have a record of the conversation or a written apology. A third had a record of the conversation but not of a written apology. The fourth was said by the Trust not to have triggered the duty because the harm had arisen from a surgical complication. However, this decision was not correct because the duty covers moderate or severe harm arising from all unintended or unexpected incidents, including those arising from known risks.

We also reviewed Trust wide provision for Estates and Facilities. Issues around the estate and cleanliness of the hospital were raised at our previous inspection.

Since our last inspection the risks to the estate have now been recognised by the trusts board and steps are being taken to address this in the form of an estates management review, and replacement where necessary. A review and introduction of management systems a backlog maintenance program (£38 million), a maternity capital project (£9.5 million) and an emergency department capital project £50 million.

New appointments had been made in the estates senior management team including recently appointed Estates Manager (in post approximately 6 months) and newly appointed capital manager (in post 2 weeks).The estates manager was making a positive impact on the department by targeting resources in areas of greatest risk and developing required policies. There was still much to be done to get the service where it needs to be, but the improvements made to date were very encouraging.

The capital manager was recently appointed and needed to establish an oversight of the capital program and its delivery and the risk priorities associated with the backlog program. Fire risks associated with backlog need to be addressed as a priority.

Estates governance was poor with few approved policies and standard operating procedures (SOP's) in place, hence many statutory duties are not compliant, with Authorising Engineers (AE's), Authorised Persons (AP's) and Competent Persons (CP's) not being formally appointed as a consequence. Frimley Park Hospital policies were being adopted as a stop-gap however, this need to be fully addressed. It was observed that Authorised Persons (AP's) and responsible persons (RP's) were not appointed by the Chief Exec' (Trust Responsible Person) as is required by the approved code of conduct (ACOP). It was also observed that Trust policies were not signed off by the CEO as should be the case.

The hospital was mostly clean. During the inspection we accompanied an auditor on an inspection of ward 9. Not the entire ward was audited 8 areas within the ward were looked at, the auditor said this was standard practice. There were potentially 44 areas to be audited on ward nine. We observed a thorough check of the cleaning within the areas that were audited, with the auditor checking against the 49 elements within the National Specifications for Cleanliness in the NHS (NSC). Outside of the audit process we checked the cleaning on wards one, five, nine, 24, 21, 22 and the neonatal unit. All wards were found to be clean and to a standard expected.

However, the facilities department were not following the NSC by not using the percentage pass rate for very high risk and high risk areas, and not following the frequency of audits for very high risk category areas. There was also evidence of the frequencies not being used consistently for high risk areas.

The cleaning audits were carried out by a dedicated team. During the inspection we checked two months of audits scores, August 2015 and September 2015. We were shown the percentage pass rate used at Wexham Park Hospital and for very high risk it was 92% with 90% for high risk areas. The NSC pass rate for very high risk is 98% and the NSC pass rate for high risk areas is 95%.

The NSC states the frequency of audits for very high risk areas should be once weekly, the trust were auditing these areas monthly. The NSC states the frequency of audits for high risk areas should be once monthly, the trust were not consistently auditing these areas monthly. Six areas we looked at had missed their monthly audit two months running and therefore were being audited at a maximum frequency of every three months. The audit frequency of every three months, according to the NSC, is for risk category "significant risk". These areas did not fall into this risk category.

We were shown no evidence that any evaluation or risk assessment of reducing the percentage rates and frequencies had been carried out by the Trust. When asked the lead for Facilities was aware of the NSC percentage pass rates and told us that the auditing percentages and frequencies had been increased at the hospital from previous years audits.

We found that microfiber cloths were not being used correctly by cleaning staff, We were told all staff who carry out this task were trained in the 'four folding method'. We checked 15 staff training records and all had recorded that this training had taken place. We witnessed seven members of domestic staff using microfiber cloths both in ward areas and public areas, one member of staff used the cloth in the correct manner as dictated by the company supplying the cloths and the industry standard the other six members of staff did not use the cloth correctly. Not using the microfiber cloths in the correct manner could lead to cross contamination of surfaces, when the cloth was not folded or changed between surfaces and or areas, however these surfaces may appear visibly clean.

# Urgent and emergency services

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Outstanding |
| Well-led | Outstanding |
| Overall | Outstanding |

## Information about the service

The Emergency Department (ED) at Wexham Park Hospital receives all accident and emergency cases, apart from major trauma cases, which are taken to other hospitals by the ambulance service.

The services at Wexham Park hospital have been managed as part of Frimley Health NHS Foundation Trust since October 2014. Since then the trust has worked on re-designing the service to improve patient flow through the department. A nurse assesses patients arriving by ambulance or on foot, and then triages them according to the severity of their condition. Patients are seen in an initial assessment area which has ten treatment bays, the major's area with 22 bays or the minor injuries and illness area with eight bays. There is also a resuscitation area with six bays where staff assessed and treat patients with the most serious conditions. The minor injuries area is staffed by GPs contracted by the trust and advance nurse practitioners. Medical staff from the emergency department support the minor injuries area when needed. There is an isolation bay for treating patients with a condition, which might be transferable to other patients.

Young people are treated in a separate area of the department which is decorated and designed for children. Children are treated in are six bays and there is a separate room for adolescents. The children and young people's service operates 24 hours a day providing a service for young people up to the age of 16. Young people older than 16 are offered a choice of being seen in the children and young people's area or in the adult area.

Nurses manage an inpatient emergency department decision unit (EDDU) which is next door to the ED. Doctors from the main ED area support nurses in the EDDU to provide care for patients. This area has 10 beds organised into two four bed bays and two side rooms. Patients are assessed by occupational therapists to identify what support they need to enable them to return home.

Patients in the ED who require an x-ray are transferred to the radiology department. There is one mobile x-ray machine in the ED, which can be used in an emergency and is operated by radiology department staff. Since our previous inspection, the hospital has reviewed how the ED worked with other departments in the hospital. This has resulted in the hospital introducing a new 'medical model', which involved senior medical staff from the medical department having a presence in ED until 8pm. One consultant works jointly between the intensive care unit (ITU) and the ED and is able to provide advice and support for critically ill patients and oversee their transfer from ED to ITU.

The department saw 110,000 patients in 2014-15. This number had risen by 9.7% in 2014/15, compared with the previous year. The majority of the additional patients were adults. The number of children seen was similar to previous years at just over 26,000. The department was built to accommodate 70,000 patients per year. This meant the department was treating considerably more patients than it was designed for. Plans for a new emergency care centre had been developed with building due to start in 2016. Staff in the department had contributed to the design.

During our inspection, we spoke to 24 patients and their relatives, and 28 members of clinical and non-clinical staff.

# Urgent and emergency services

We looked at the records of 10 adult and 10 paediatric patients. We spent two days observing care being provided during the day. We also visited the department in the evening to see how the service operated outside the hours of 9am-5pm.

## Summary of findings

Overall we rated the emergency service at Wexham Park hospital as 'Outstanding' because:

Since our last inspection in 2014, a new leadership structure had been developed. Consultant medical staff now provided leadership for some aspects of the service, such as clinical safety and patient experience, clinical governance, education and training. There had also been changes to the senior nursing team with the appointment of matrons who now oversaw the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for. We found these changes had resulted in sustained improvements in the quality of care patients received.

At our last inspection we were concerned that some patients spent a long time in the ED waiting to be seen. The service had difficulty meeting the national quality standard for 95% of patients being seen in less than four hours. At this inspection, we found the trust had met the four hour quality standard since February 2015. Patients were assessed quickly and the service had met the national quality standard for 95% of patients being seen in less than four hours since February 2015.

Consultant medical staff provided effective leadership of the service such as clinical safety and patient experience, clinical governance, education and training.

Senior nurses took responsibility for the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for.

The service was well co-ordinated through board rounds held four times a day and clinical practice was audited against the standards set by the College of Emergency Medicine (CEM). Guidelines were accessible and followed by staff.

The ED audited clinical practice against the standards set by the College of Emergency Medicine (CEM). The college of emergency medicine is a body which sets national standards for emergency services. The department was also part of the Thames Valley Trauma Network, which aimed to develop high-quality trauma

care across all the hospitals in the area. This involves the ED service being reviewed against a set of national quality standards and undergoing a quality review by clinicians providing similar services in other hospitals.

The ED had a system in place for monitoring changes in a patient's condition. The Detection of Deterioration (EDOD) scoring system was used when patients were first assessed and to monitor their condition during their stay in the ED. Similar systems were in place for both adults and children. Staff monitored each patient's condition and were able to reduce the risk of unsafe care if they deteriorated.

When we last visited the hospital we found the number of patients waiting between four and 12 hours and longer than 12 hours for admission was much worse than the England average. At this inspection we found that the number of people waiting longer than 12 hours for admission had reduced steadily from 23 in April 2015 to five in June 2015. This reduction may reflect a difference between the seasons with fewer admissions required during the summer months. However, the hospital had also been working on a range of ways of improving the movement of patients from the ED to other departments which had contributed to this reduction.

At our previous inspection we found that patients who were waiting a long time for admission did not have the condition of their skin checked and were not offered anything to eat or drink, both of which are good practice. At this inspection we found staff had improved the care provided and now monitored the condition of patient's skin and provided food and drink to those waiting.

Staff delivered care based on best practice national guidelines. At our last inspection we found staff had good knowledge about the guidelines and audits in place, but were less clear about how improvements were going to be implemented. At this inspection we found that the hospital had strengthened the structures for overseeing the implementation of guidelines and there were effective, clear written information accessible on the computer for all staff working in the department.

Staff spoke positively about the considerable changes that had taken place over the last 12 months and the pace at which this had been achieved. They told us the leadership of the department provided clarity about the vision for the service and senior medical and nursing staff provided support and direction. Consultant medical staff had highly visible leadership responsibilities for improving the quality of service which staff believed was making a positive difference. Staff told us they felt more motivated, supported and energised. They were proud to work in the ED because the leadership and culture had improved.

The ED had worked with other departments to reduce the length of time patients waited to be admitted. Three additional consultants had been appointed, which enabled senior staff to have a greater presence in overseeing the work of the department. Senior nursing staff also spent more time supervising the quality of patient care.

Consultant medical staff had visible leadership roles for clinical governance, safety and auditing, and staff felt supported and confident to raise issues and concerns.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

The need to improve access to CT scanning. There is currently only one scanner on site. Patients were diverted to another hospital when the CT scanner was out of action. the trust planned to provide a second scanner when the new emergency department is built however the Trust should seek to ensure all patients requiring a CT scan were able to receive one, at the earliest opportunity.

Pharmacy support for the department was limited to 16 hours a week. Patients in emergency department decision unit (EDDU) needed their medicines reviewed before they could return home the lack of pharmacy support sometimes led to delays in patients being discharged.

A new major incident plan had been developed but not all staff were aware of it. The plan had not yet been rehearsed or tested but a simulation was planned.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good

We rated emergency service at Wexham Park hospital as 'Good' for 'Safe' because:

- There were good systems in place for ensuring patients were treated safely. Clinical safety was a high priority for the emergency department (ED).
- There was a well-developed culture of incident reporting and staff learned from incidents, errors and near misses. There were effective rapid assessment arrangements to determine the seriousness of patient's condition so that they could be treated in the most appropriate area of the department.
- The ED team met four times a day, led by a Consultant, to review the condition of patients being treated in the department. Senior medical and nursing staff monitored the care being provided and supported staff throughout the department escalating to the appropriate clinician to ensure patients received safe and effective care. There were effective rapid assessment arrangements to determine the seriousness of a patient's condition so that they could be treated in the most appropriate area of the department.
- Consultant cover had improved since our last inspection following the appointment of three more consultants but still fell short of the College of Emergency Medicine Standards. The number of nursing vacancies had reduced by half over the last twelve months and the department was able to cover the majority of shifts with bank staff who were familiar with the service.
- The department was clean and staff followed good hygiene practices. A system for auditing compliance with cleanliness standards was in place.
- There were effective arrangements in place for safeguarding vulnerable adults and children.

However, we found some areas that had scope for improvement.

- Access to pharmacy support was limited to 16 hours per week. The pharmacy department acknowledged this was a high priority for expansion over the next year.
- The hospital relied on one CT scanner, which meant when this was out of action patients had to be diverted to another hospital.
- Records were kept of the daily checks on equipment needed in emergencies. The records were mostly completed but there were gaps of several days where it was not clear if the equipment had been checked. When we spoke with senior nurses about this they told us a system of monthly audits had been put in place to make sure all ward and departments were checking their equipment on a daily basis..

### Incidents

- Clinical safety was a high priority for the ED. Incident reporting was encouraged and the service had developed effective mechanisms for learning lessons from incidents and for ensuring actions were taken to reduce the risk of similar incidents occurring in the future. There was a robust clinical governance structure in place with effective clinical leadership. Medical and nursing staff were fully involved in learning from incidents. A patient representative attended clinical governance meetings to advise staff on improvements.
- There was representation from other departments and services that the ED worked closely with, including paediatrics, pharmacy, mental health and the ambulance service. The clinical governance group had an action plan and monitored the actions agreed until they had been fully implemented.
- A departmental safety group met monthly. During the group's meetings, staff were encouraged to raise concerns about any aspects of safety within the service.
- There had been no 'never events' at the service since our last inspection. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventive measures are implemented. The ED had reported five serious incidents to the strategic executive information system (StEIS).The serious incidents reported were delays in diagnosis, failure to act upon test results, failure to provide a patient with the appropriate medicine, falls and issues relating to a high number of patients attending.
- The department had developed and strengthened clinical governance arrangements. Staff told us that patient safety was a priority. Medical and nursing staff told us they were encouraged to report any concerns about clinical safety. They also told us incidents that

were reported were investigated and changes were made to improve patient safety. We saw the department had investigated the incidents and made changes to reduce the risk of the same incidents re-occurring.

- We saw a report that analysed serious incidents in detail. The report included recommendations. We saw a root cause analysis had been carried out on some incidents. This was a process hospitals use to carry out a detailed analysis of patient safety incidents. Other incidents had been reviewed against the college of emergency medicine and national institute of care excellence (NICE) guidelines by the mortality and morbidity review group. Monthly clinical governance meetings were chaired by a consultant who provided leadership for clinical safety within the department. Clinical incidents were discussed at the clinical governance meetings and actions were agreed to make sure the same error did not occur in the future. Staff who were unable to attend were sent information by email about the actions that had been agreed. A newsletter was also distributed which summarised the incidents and actions agreed. The clinical governance group monitored progress until the actions were fully implemented. We saw an example of a newsletter dated July 2015, which described the incidents reported and the action taken as a result.
- We saw examples of changes that had been fully implemented, and plans to carry out future audits to check the changes were being sustained. For example, a procedure had been developed for re-directing or transferring patients to another ED when the CT scanner was out of action. A dementia nursing champion had been identified to help identify and care for patients with dementia. Regular audits of patient notes had commenced. Staff had also received training in recognising patients who may have suffered a stroke.
- Incident reports were analysed to identify trends. For example, all falls and pressure ulcers for patients in ED were recorded and analysed to increase staff awareness. There were 47 medication incidents reported in 2014 2015 in ED and 20 reported between April and September 2015. One of these was reported as a serious incident when a patient was not given a medicine before their discharge and returned to the hospital with a more serious condition. As a result of reviewing the incident, new procedures were put in place to reduce the likelihood of the same issue occurring again. We saw that teaching sessions were organised to embed the learning from incidents. For example a training event had been organised for junior medical staff following an incident where a patient's fractured wrist was not manipulated to improve the angle of the wrist.
- The care of people who had died or whose condition had deteriorated significantly were reviewed to identify if anything could have been done differently. The ED also reviewed the care of patients who had been admitted from ED to the Intensive Care Unit (ITU) to improve the quality of care provided to people with the most serious conditions. The records of the meetings showed that the lessons learned were discussed and information about changes to improve the service was circulated to staff.
- Examples of incidents investigated included a missed diagnosis, prescribing powerful medicines to control pain and the importance of assessing patients who may have developed sepsis, a dangerous blood condition. Action had been taken to reduce the likelihood of similar events happening in future. The lack of nurses trained to give intravenous therapy had also been discussed in May 2015 and additional staff had been trained as a result. Incidents which had nearly occurred were also reviewed. For example, staff realised the wrong patient was about to receive a CT scan, but staff were able to prevent the error occurring.
- The emergency department decision unit (EDDU)used the NHS safety thermometer to check patients were protected from developing a pressure ulcer, urine infection, falls or venous thromboembolism. The reports showed the service had provided 95.6% harm free care during 2014-2015 and an average 95% harm free care since March 2015. This meant staff were regularly checking that patients were protected against the risk of these forms of harm.
- Duty of candour fields were incorporated into incident reports for moderate and more serious incidents. This was designed to ensure staff were being open and transparent with patients and their relatives when things went wrong. From April 2015 all healthcare providers were required to ensure they were open about

notifiable safety incidents offering an apology and support for investigating the incident. Staff were recording and reporting incidents in line with the hospital's policy on duty of candour.

### Cleanliness, infection control and hygiene

- During our inspection we found the department was mostly clean and saw records of cleaning audits had been carried out monthly by the cleaning service supervisors. We spoke with one of the matrons responsible for cleanliness and infection control. They showed us the results of the audits. These highlighted areas for improvement, which included ensuring equipment trolleys and high areas were free of dust. We checked and found most of these issues had been resolved. However, we found dust on emergency equipment trolleys and dust on the air conditioning vents in the ceiling, which had been one of the issues highlighted in the audit. This meant that the audit process was highlighting issues which were not always being addressed.
- We found the other issues had been addressed and overall the department was clean. We observed staff using anti-bacterial hand gels when they entered and left the department and when moving from one patient to another.
- Hand hygiene audits were carried out which showed an 89% average compliance in ED and 91% in EDDU. The hospital carried out audits every month which showed rates had improved between April and September 2015 from 89% to 93%. There was a band 7 hand hygiene champion in the department. Hand hygiene training was regularly provided. The department had a major programme in August 2015 during which a third of staff received training. We saw a nurse with a treatment tray that had been prepared in the treatment room in readiness for treating a patient. We observed that they were wearing protective gloves and apron.

### Environment and equipment

- The ED environment had been improved in 2014 to provide additional treatment cubicles. Services in the resuscitation bay had been developed to provide similar levels of care to the intensive care unit (ITU). Trauma mattresses had been purchased to help transfer injures and immobilised patients within the department.
- A more child friendly environment had been created in the paediatric area following refurbishment in the last year. The adult and children's areas were located in separate but adjacent areas. Access to the children's emergency area was security controlled and monitored via CCTV cameras. Patients and visitors wishing to access the paediatric area had to contact the main reception area via an intercom before being permitted to enter the department.
- There were three security staff on site between the hours of 7pm and 7am. Security staff had received level two control and restraint training and attended if staff within the emergency department required support with patients who were violent. Security staff were only used on the instruction of clinical staff.
- We saw the airway trolleys had been re-organised to be similar to ITU and theatres following a review of airway management held on 21 January 2015. This meant the department were adopting good practice from other areas of the hospital to ensure equipment was well organised to help staff find the correct items quickly.
- When we visited the radiology department staff told us they prioritised patients from to minimise the length of time patients had to wait. There was one mobile x-ray machine located within the ED. This was used in emergencies when the patient could not be transferred to the x-ray department Radiology staff would attend the ED on these occasions. The hospital had one CT scanner, which on occasions was not available. The emergency department had developed a procedure for diverting patients to another hospital if the CT scanner was not available. The hospital had developed plans for providing an additional CT scanner because of the potential risks to patient quality and safety.
- We saw the children's emergency equipment trolley was checked daily. This meant staff knew the equipment needed in an emergency would be safe to use. We looked at the records of checks carried out on the resuscitation trolleys in the adult area of the department. There were no records of any checks for 12 one trolley for a period of 12 days.
- At our previous inspection the relative's room was in a shabby condition. At this inspection we found there was now a pleasant environment for staff to meet and talk to relatives. The room was refurbished.

- A nurse had recently been appointed to a new role within the hospital for ensuring systems were in place to provide effective care for deteriorating patients. They told us they had put monthly audits of resuscitation equipment in place because they were aware records of equipment checks were not always completed. Both trolleys in the rapid assessment and majors had gaps in the records and were dusty. Without a record of checks there was a risk that equipment needed in an emergency might not work.
- Other equipment was checked in April 2015. We saw maintenance records for these equipment checks.

### Medicines

- The ED did not have full time pharmacy support. The Chief Pharmacist told us that ED was a high priority for investment with additional pharmacist support for 2016. The department had support from a pharmacist for 16 hours per week. Staff told us the pharmacist who supported the department provided a good service in the time they had available. They said patients on the emergency department decision support unit (EDDU) often had complex needs and staff needed pharmacy advice about managing their medicines. We saw an example of an incident that highlighted the need for daily medicines reconciliation in the emergency department decision unit. Staff told us it was not always possible to access advice and support when they needed it and there was a risk of delays in obtaining advice about patient's medicines. The ED safety group had discussed this and identified it as a safety risk.
- We saw this had been discussed at Nursing staff within the ED were able to prescribe medicines for example for pain relief. We reviewed the documentation that authorised nurses to prescribe certain medications and found the appropriate authority was in place.
- Appropriate arrangements were in place for recording information about the medicines patients received. The prescriptions and records of administration that we looked at were succinct and legible. We observed that medicines were locked away when not being dispensed which meant they were being kept safely.

### Records

- Electronic clinical records via bed-side terminals allowed quick access and record entry for clinicians.
- The department had introduced a new computerised patient record system, which meant patients could be tracked through the department. The computer system also generated improved electronic discharge summaries for GPs. Medical notes were completed on paper records, which were scanned on to the system. Minor illnesses or injuries could be recorded directly on to the system. Pathology and x-ray requests were submitted electronically, which reduced the risk of errors associated with hand written requests. Staff could access computer terminals located in patient cubicles. This meant they could record information and request tests while at the patient's bedside. We reviewed 20 sets of patient's records, 10 adult and 10 paediatric notes. We found these contained completed pain scores, early detection of deterioration (EDOD) scores and sepsis screening assessments. We saw that not all patients had a priority score. The senior nurse on duty explained that staff recorded this information on the computer system.
- The department had a system in place for auditing the quality of record keeping. We saw examples of records audits from May to August 2015. These identified levels of compliance with required standards, good practice or 'stars' and 'could do betters' based on a monthly review of 10 sets of patient's notes.
- Staff learned about any changes to documentation or recording required following the investigation of an incident. We saw an example of a drug chart staff had changed to include a section for the prescription of oxygen and nebulisers

### Safeguarding

- There were appropriate processes in place for safeguarding people against abuse. Safeguarding training was part of the department's mandatory training requirements for all nursing and medical staff.
- We saw examples of good liaison with the adult safeguarding team alerting them to the possibility of a vulnerable person arriving in the ED.
- Both medical and nursing staff carried out safeguarding checks for each child before discharge. The ED IT system prompted clinicians to record any safeguarding concerns.
- A liaison health visitor worked with the department to provide community services with information about

children who had attended the emergency department and might be at risk of abuse. Medical and nursing staff we spoke with understood the processes in place for safeguarding adults and children from abuse. There was information available in the hub office about safeguarding arrangements together with the contact details of the relevant agencies.

- Information about older frail patients recorded on to the computer system resulted in alerting the frail elderly team.
- The department had a domestic violence lead. They had developed training programmes for staff and a domestic violence advocate role with charitable funding. As part of the training they raised staff awareness to issues such as forced marriage and the role of medical and nursing staff in protecting people. They had produced a booklet about a range of topics for example female genital mutilation, transgender issues and advice for men and women about domestic violence. The member of staff had received a national award for their work.
- Senior medical staff had all completed training in safeguarding adults and children, and consultant medical staff had all completed level 3 safeguarding training for children. All but two other medical staff had received level 2 training. The ED training lead told us they understood the importance of completing the necessary training and they would ensure all medical staff completed training as soon as possible.

### Mandatory training

- The hospital was in the process of updating the computer training system with records of mandatory training staff had completed at Wexham park hospital. The department had kept local records of the training staff had completed. The list of mandatory training subjects had been agreed which included conflict resolution, dementia, emergency planning, fire safety, health and safety, infection control and safeguarding.

### Assessing and responding to patient risk

- When patients first arrived at the emergency department they were assessed. An early warning system was in place for identifying when a patient's condition was deteriorating.
- A triage nurse located close to the reception area assessed patients and decided where to send them for treatment for example either to the rapid assessment or minor injuries area. Ambulance staff who brought patients to the department could take patients immediately into the assessment or resuscitation areas.
- A scoring system was in place to alert staff if a patient's condition was deteriorating. The EDOD system was in place for both adults and children in the main department and the Emergency Department Decision Unit. Patients received an EDOD score when they were first assessed. If the person's condition changed the score was altered. Staff in ED could call specialist critical care staff to assist them if a patient's condition deteriorated. During our visit we observed one patient moved from EDDU to the resuscitation area where they could receive more specialised care because their condition had deteriorated.
- Records showed staff used children's early warning charts when speaking with young patients. This recorded vital signs and alerted staff to any deterioration in a child's condition.
- Staff we spoke with were familiar with the scoring system and knew to alert the senior nurse or doctor if the patient's score changed. Scores were being recorded throughout the time patients remained in the department.
- The initial assessment forms also contained a section designed to assess the risk of sepsis (this was a College of Emergency Medicine standard).Following work carried out to improve recording risks were identified effectively. An audit carried out in August 2015 showed good levels of compliance. However, when we reviewed one person's records we saw staff had ticked two of the risk factors for sepsis but had not referred the patient to medical staff as the department's sepsis policy required. This meant there was a risk that the service did not identify all patients who might develop sepsis.
- Reception staff told us they could alert the triage nurse to any patients they were concerned about. They said an emergency call button was installed in the reception area following an incident and they had been able to use this to call for help when a patient fainted.
- The service had developed a policy for transferring children safely from ED to the ward and there was link a nurse in children's ED for liaising with the ward.

# Urgent and emergency services

## Nursing staffing

- We looked at the number of registered nurses on duty in the department. The matrons told us the department had been successful in recruiting additional nurses in the last year and the number of vacancies had fallen from 12% to 6.4% (18.42 nurses).The ED had the highest reliance on bank staff within the hospital. However, the use of agency staff for the period January – June 2015 had reduced. Approximately 90% of all shifts for trained staff were filled during the period April – July 2015. Eight-five
- Staff sickness levels were less than average sickness rates in the hospital at 2.89% for nurses and 0.89% for medical staff for the year April 2014-March 2015. This represented an improvement in medical staff sickness rates.
- At our last inspection we found that agency nurses were not always fully trained, briefed or supervised. At this inspection we found bank and agency staff received an induction 'boarding pass' at the beginning of their shifts if they had not previously worked in the department.
- Staff told us they were not clear whether staff shortages should be reported as an incident. We asked one of the senior nurses about practice in the department. They told us there were escalation processes in place to ensure adequate staffing, which often meant staff were re-deployed to cover the unit. We observed the department during a busy period when there were 61 patients in the department. We saw the nurse in change checking each of the areas to see if staff needed assistance.
- Advanced nurse practitioners worked independently in the minor injuries area from 07.00 until midnight seven days a week.
- Staff told us, "teams in ED worked well together and are well led by the band 5 nurses". Staff were encouraged supported to complete an apprenticeship and felt supported.

## Medical Staff

- The College of Emergency Medicine (CEM) standards specifies that there should be consultant cover 16 hours each day. Consultant cover had improved since our last inspection following the appointment of three more consultants but still fell short of the CEM standards. The Chief of Service told us there were two consultants available between 8am and 5pm and one consultant between 4pm and 10.45pm then on call overnight. There was a minimum of one consultant available for nine hours on Saturdays and Sunday with an on call consultant out of hours. One registrar level doctor was present in the department every night. The Chief of Service told us they were continuing to try to recruit additional consultant medical staff so that they could comply with the CEM standards. When compared to the England average for other trusts there were 8% fewer consultants and 7% fewer middle grade doctors. These are doctors who have worked for at least three years at senior house officer grade or higher. There were 25% more registrars when compared to the England average trust and 9% fewer junior medical staff. For the period April – July 2015 between 91.17% and 88.71% of medical staff shifts were filled.
- Two consultants had sub-speciality qualifications in paediatric emergency medicine and another was qualified in both intensive care and emergency medicine. This consultant held a joint post between ED and ITU. This meant the skills of a doctor trained in managing people who needed more intensive care were available to treat patients, manage their transfer to the intensive care unit and provide supervision and teaching for junior medical staff.
- There had been an improvement in the number of junior medical staff employed by the department. At our previous inspection we found the service relied on cover from locum junior medical staff who were often difficult to find. At this inspection we found the reliance on locum doctors to cover the rotas had reduced from 20% to 11%. The workforce co-ordinator who organised the rotas told us recruiting locums had become easier in the last 12 months. They told us they were often able to use the same locum staff to cover over longer periods. Potential locum doctors were contacting the department to enquire about vacancies.
- Average hourly patient attendances were used to identify the number of junior medical staff required for each shift. We reviewed the rotas for the last month and found the rotas were fully covered. There were some shifts where the number of staff on duty exceeded the number required on the rota.

# Urgent and emergency services

- Medical and nursing staff were all involved in four hourly 'board meetings' which included handovers between shifts. These meetings in the 'hub' office, an area of the department where staff exchanged information, updated patient records and accessed information, which might be important to them that day. These multidisciplinary board rounds were held at 8.00 am, 12.00pm, 4.00pm and 10.00pm. We observed all four meetings during our inspection and saw consultant medical staff led these. The meetings focused on patient safety and high priority groups, such as people with dementia. Medical and nursing staff agreed their roles for the day and there were updates on the availability of beds in the hospital and any problems with radiology and other services.

### Major incident awareness and training

- A revised major incident policy was completed in September 2015 together with updated incident cards for key personnel with contact details. We saw the major incident storage area was now in a more accessible for staff working in the department. The service had not practiced the new policy for a mass casualty incident but there were plans to carry out a table top exercise.
- Band 7 nursing staff had attended a major incident training event. A training event for the department would take place shortly after our inspection. Staff we spoke with were aware the major incident policy was updated. They told us the department had dealt with several different incidents that had helped them prepare for incidents in the future. For example, staff told us they had recently had a disruption to their water supply but been able to continue to provide a service to patients. The department had developed arrangements for dealing with casualties contaminated with chemical, biological or radiological material (HAZMAT).We saw the department's risk register had identified the lack of chemical, biological or radiological training as a key risk. Senior nursing staff told us this remained a risk until all staff had been trained and procedures were fully in place. There was a supply of CBRN equipment in the department and decontamination showers were available.
- Business continuity plans had been developed to deal with emergencies, such as loss of IT or bad weather.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated emergency services at Wexham Park hospital as 'Good' for 'Effective' because:

- The ED had reviewed and updated clinical policies and guidelines, which staff could access on the hospital's computer system. Policies and guidelines were based on national guidance from the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine.
- There was an extensive programme of national and local audits in place and the results were regularly reviewed and fed back to staff. The Thames Valley Trauma Network reviewed the service in January 2015 to assess how the department met national standards for trauma services.
- Medical education authorities found there was good education and supervision for junior medical staff when consultants were present in the department. A nurse educator post had been established in the department. They provided preceptorship to new nursing staff joining the service.
- Joint working arrangements were in place with the ambulance service, the mental health liaison team, the paediatric and palliative care teams.

### Evidence-based care and treatment

- We saw the notes of a major trauma group which met monthly. This was chaired by a consultant from the ED service and involved representatives from other specialties such as orthopaedics, plastics, radiology and surgery. The group was concerned with identifying and delivering best practice in trauma care and compared their performance with other similar services.
- The Thames Valley Trauma Network reviewed the service in January 2015 to assess how the department met national standards for trauma services. The results of the review showed the Wexham Park ED met 10 out of the 14 standards for reception and resuscitation, eight out of the 10 standards for definitive care and three out of the five standards for rehabilitation. The national

trauma peer review, a national quality assurance programme for NHS trauma services, comprises self-assessment and external review by professional peers against nationally agreed quality measures. Concern was raised about the service's ability to access CT scanning within 30 minutes of the request and that all CT scans should have a provisional report available within 60 minutes.

- We saw from the records of a training session for junior medical staff that national guidance on managing seizures had been discussed. The 2014 national survey of patients attending ED found the trust compared about the same for the time taken to provide pain relief, help to control pain and the availability of food and drinks in the department during their stay.
- The department was following the College of Emergency Medicine (CEM) policies and national guidelines as the basis of providing effective care to patients. Guidelines were accessible for staff on the trusts internal IT system. There were processes in place for developing, approving, implementing and auditing guidelines.
- There were guidelines in place for the management of sepsis, stroke and fractured neck or femur. Compliance with the guidelines was monitored monthly through the ED Clinical Governance group. Action plans for ensuring compliance with the guidelines had been developed and monitored. We saw that staff were informed about new clinical guidelines, which could be accessed via the intranet.
- We saw the results of the mental health CEM audit, which showed the department was below the national average for risk assessment after self-harm and documenting a mental state examination. However, it performed better than the national average for patients seen by the mental health team.
- We saw the service had undertaken a retrospective audit of 49 acute kidney injury patients to review compliance with NICE and NCEPOD guidance. The clinical governance group identified the actions to be taken to improve compliance with the guidelines.
- Staff were encouraged to undertake local audits and we saw an electronic learning module had recently been developed to train staff in how to undertake audits.
- The department participated in six major clinical trials, which included the use of tranexamic acid for the treatment of significant traumatic brain injury and the use of tranexaemic acid for gastrointestinal bleeds. A research nurse co-ordinated the departments contribution to the trials. We saw posters in the waiting area to make patients aware of the trials.

**Seven-day services**

- The emergency department is open seven days per week and twenty four hours per day. The minor injuries service was open until midnight each day staffed by GPs employed by the hospital and advanced nurse practitioners.
- The emergency department decision unit was open 24 hours a day, seven days a week. Patients who spent longer than 24 hours on EDDU were referred on to inpatient teams unless there is a specific plan for their discharge.

**Competent staff**

- We saw the Health Education Thames Valley visit report on medical education and training, which took place in April 2015. This is a body responsible for assuring the quality of training for healthcare professionals including doctors. The report stated that trainee doctors had a supportive environment clinically with good consultant supervision during the times consultants were present in the department. The report also noted that higher specialty trainees reported a positive approach to service improvement.
- Junior medical staff had a clinical supervisor during their time in the department and were required to maintain portfolios of their work demonstrating the competencies they had developed. Several consultants were trainers for advanced life support (ALS), advanced trauma life support (ATLS), paediatric life support and advanced paediatric life support (APLS). Staff told us there were opportunities for developing their skills and knowledge. They said there was in house training and access to accredited education courses. We spoke with one member of staff who told us they had been supported to train as an advanced nurse practitioner. We saw an example of a middle-grade doctors training

day held in September 2015, which covered incident reporting and paediatric radiology. A similar training day for more senior doctors covered complaints and orthopaedic injuries.

- A practice development nurse supported staff within ED preceptorship for new starters. They told us they were responsible for developing training to maintain nursing staff skills and competencies.
- They were also responsible for ensuring adult and paediatric nursing staff received the appropriate adult or paediatric immediate life support training and advanced trauma training. The practice development nurse was also responsible for ensuring agency nurses received induction training. They told us the arrangements for training and education had improved. Practice development nurses met as a group to discuss the development of training for all departments in the hospital. Junior medical staff told us there was a new trainee system for ED registrars, which enabled them to gain experience by working in anaesthetics and ITU. They told us this improved their skills, particularly when caring for patients whose conditions had deteriorated and in managing patients breathing more effectively. Some medical and nursing staff worked jointly between ITU and ED, supporting the most seriously ill patients who were transferred to intensive care.

### Pain relief

- The results of the CQC 2014 A&E survey found patients waited to receive pain relief about the same length of time as patients in other hospitals and the level of help from staff to control pain was about the same as patients in other hospitals. We saw examples of pain assessments undertaken and recorded in patient records.
- The pain patients experienced was assessed and monitored. There were protocols in place for managing severe pain in children. Staff training for managing pain for people with a fractured hip was arranged following analysis of an incident in the department and in response to CEM recommendations.
- The ED participated in three CEM pain audits for pain in children, pain associated with renal colic and pain associated with fractured neck of femur.
- We reviewed 10 sets of care records in the children's ED area and saw these recorded children's pain score. The ED computer system enabled pain scores to be recorded. There was a protocol in place for prescribing intranasal diamorphine for children in severe pain. Following an incident in the department a number of members of staff had been trained to carry out fascia lilac blocks for patients with a fractured hip.
- The service had developed a poster, which we saw displayed in the department, encouraging patients to tell staff if they have any pain. The poster had been developed in response to a complaint a patient had made about staff not responding to the pain they had experienced.

### Joint working

- Staff in the ED worked closely with other services and departments to provide an effectively co-ordinated service for patients. We saw staff from the ED and the radiology department met to monitor any problems ED patients might encounter when accessing radiology. For example, the time it took patients to have an x-ray or CT scan.
- There were arrangements in place for the ED service to refer patients to the alcohol/substance misuse liaison team who provided a drop in service. We saw leaflets were available in the department about accessing the service.
- Staff within the ED were able to refer patients to the psychiatric liaison team. The service was available twenty four hours a day, seven days a week. Access after 2am was organised by the mental health crisis team. Clinicians told us they could obtain telephone advice immediately and face to face assessments were usually within two hours.
- Children and young people who needed an assessment by the child and adolescent mental health team were admitted to a children's ward and were assessed there.
- We observed occupational therapists assessing patients on the EDDU to identify what support they might need at home before they were discharged.
- There were transfer procedures in place for trauma patients to a neurological centre. We saw these had been implemented following an incident which had led to a delay in transferring a patient between sites.

# Urgent and emergency services

- We asked about the arrangements in place for patients with a cancer diagnosis attending ED. Staff told us they contacted the palliative care team, who are based on site and who made contact with the oncology service, which is based at another hospital. Cancer patients who attend ED were nursed in a side room and would be referred to the medical department admission.
- We saw that south central ambulance service representatives attended the ED clinical governance group meetings. The department was working with the haematology department to audit neutropenic sepsis in patients who had received chemotherapy.
- A paediatrician was involved in updating paediatric antibiotics guidance, which they planned to share with ED once the guidance was finalised. The paediatric inpatient and emergency departments had also discussed communication between the wards and ED to prioritise patients when beds were full.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most medical and nursing staff had completed dementia awareness training as part of their mandatory training. Nursing and medical staff were aware of the requirements of the 2005 Mental Capacity Act. This meant clinical staff were able to assess if a patient was able to provide consent to treatment.

## Are urgent and emergency services caring?

Good

We rated emergency services at Wexham Park hospital as 'Good' for 'Caring' because:

Staff in ED provided patients with a caring and compassionate service. Patient's dignity was respected and staff were aware of the customs of different cultures and religions.

Staff were aware of people's individual needs and considered these when providing care.

We observed care being delivered and found staff were compassionate and caring. The senior nursing team had introduced a system for monitoring the quality of care provided. A nurse in charge was identified for each area within the department to check patients were being well cared for.

At our last inspection we found patients were not offered anything to eat or drink. At this inspection we found food and drink was available and offered to patients. We also found systems were in place to monitor patients in the department and monitor their pressure areas.

The friends and family test results showed that over 80% of the people who responded would recommend the ED during the period April – June 2015. The response rate to the survey had improved from 10% at the last inspection to 20% at this inspection. Staff told us they were actively encouraging patients to provide feedback, however it had fallen in October 2015

### Compassionate care

- Staff told us senior nurses regularly monitored the quality of care patients received and we observed advice and support being offered to junior staff.
- We saw the department had begun sending condolence cards to families three weeks following a death in the department.
- We observed support staff providing food and drinks for people waiting in the department. After 11pm a tea trolley was provided in the major's area for hot drinks and snacks. New vending machines had been installed in the waiting area.
- The service had developed champion's roles. Champions were nursing staff who provided colleagues with information and advice about providing support for patients with dementia, domestic abuse, and pain and alcohol abuse.
- Members of the senior nursing team attended the trust meetings of the Trust Patient Experience Forum where they were able to discuss patient's experiences and ideas for how these could be improved.
- The department had introduced the Clinical Institute Withdrawal Assessment (CIWA) to help support patients with alcohol withdrawal symptoms.
- Staff we spoke with understood the bereavements customs of different cultures and religions.

# Urgent and emergency services

- The paediatric emergency department had been decorated to make it more children friendly. A play therapist supported children for 23 hours per week. However, staff told us the number of play therapists had reduced from four to one. The play therapy service was provided for four hours per day.
- One person told us they had a very positive experience of the ED service. They were an advocate who had visited the department with a patient who had a mental illness. The person had very challenging behaviour. They said staff were very calm and supportive whilst they waited for the mental health team to attend and review the person. The person had been in the department from midnight until they were assessed at 11.00am the next day. The advocate told us there had been several changes of staff. They said new staff coming on duty were aware of the person's needs and treated them with dignity and respect. They said staff were very understanding and caring and made arrangements to ensure the person and other patients in the unit were safe. Another person said 'I am really happy with my care so far and have received pain relief.'
- One patient we spoke with told us, "My care felt individual to my needs. I felt I was being monitored and I was seen by two doctors. They said staff had changed the curtains in their treatment bay. They said staff had asked their permission before they changed them, which they thought was "lovely".
- Another person told us they felt, "Rushed when I first got here and then I was left not knowing what's going on for three to four hours." They said triage was not explained and that staff were being over friendly because the CQC were visiting.
- One person told us, "I don't like the personal questions they ask me about my children as they don't live with me so it's nothing to do with them. They said, "I feel as if staff look down on me because I have cut myself. They don't seem to understand I am ill and I need treatment."

### Patient understanding and involvement

- We observed care being provide in all areas of the emergency department and saw staff preserved patient's privacy and dignity by closing cubicle curtains when patients were being examined. We also saw staff speak with patients in a caring way.Patients and relatives told us the nurses were all very kind. Staff lowered their voices to prevent clinical or personal details being overheard.
- The results of the CQC 2014 A&E survey found the department performed as well as other hospitals on a range of aspects caring for patients. The questions patients had responded to covered areas such as doctors and nurses listening to what the patient had to say, being treated with dignity and respect and if the patient had confidence and trust in the doctors and nurses. The responses to questions about patients feeling involved in decisions about their care and treatment, being given contradictory information by and being able to discuss anxieties about their condition were worse than other hospitals. The responses were similar to patient's responses at other hospitals for a total of 21 questions out of 24.
- Some of the patients and relatives we spoke with were attending the paediatric emergency department. One person said, "The care is really good; the only complaint I have is about difficulty parking."
- We spoke with a young person who told us, "I am very happy so far; the nurse was nice and understood what I needed."
- Another young person told us told us they were happy with the care they had received and a mother who was attending with her baby told us the care they had received was excellent.
- Parents and carers spoke highly about staff in the paediatric ED and told us they were caring. During our inspection a child who was acutely ill was received initially in the resuscitation area. Paediatric trained staff attended the emergency before the child was stabilised and transferred to the paediatric area and could treated in a more child appropriate environment.

# Urgent and emergency services

**Are urgent and emergency services responsive to people's needs?**
(for example, to feedback?)

**Outstanding** ☆

We rated emergency services at Wexham Park hospital as 'Outstanding' for 'Responsive' because:

The number of patients attending the department had risen by 9.7% in 2014-15 compared to the previous year. Staff told us the population served by the department had increased following the closure of another emergency department. The department was treating more patients than it had been designed to accommodate. It saw 110,000 patients in 2014-15, but the department was only designed to treat 70,000 patients per year. Despite this rise the performance of the service had improved markedly since our last inspection. The service was able to respond to increased demand and achieve the national quality standard for seeing 95% of patients in less than four hours.

The ED team had re-designed patient flows within the department and worked with colleagues in other specialties to improve the processes for admitting patients to the wards. There were plans in place to deal with surges in demand. The number of patients leaving the department without being treated had reduced and patients and ambulance staff told us the department was better organised.

The relatives room had been upgraded since our last inspection and now provided a pleasant area for relatives to talk to medical staff.

### Meeting people's individual needs

- We saw events had been organised to review the department's performance and ways in which the service could be improved for example by improving the pathways for people with a learning disability or dementia.
- Staff working within the ED recorded the languages they spoke on a white board in the hub office so staff knew who could help with translation. Staff ensured they knew which languages patients spoke. A sheet the department had developed enabled patients to identify the language they spoke. There were signs in different languages within the department and signposting people to the ED.
- There was a leaflet in 18 languages explaining the availability of translators. A cancer peer review found there was no robust flagging system in place to alert clinical staff at the point when patients present in ED. These meant decisions about a patient's treatment could be made without access to the patient's most recent clinical information and could, as a result, affect the quality of their care. Information identifying cancer patients in ED within the previous 24 hours was collated. This was forwarded to the palliative care team if the patient was discharged to alert them to the patient being seen in ED.
- A room was provided for patients with a mental health problem. Mental health staff could assess the patient's needs in an a quiet, private area away from the main department.
- The relatives room had been upgraded since our last inspection and now provided a pleasant area for relatives to talk to medical staff.
- An emergency department decision unit provided early decision making capability for patients with a low clinical risk who were likely to be discharged after a short period.

### Patient flow

- Patient flow through the department had improved and waiting times reduced after the department was re-designed. Increased consultant availability, following the appointment of an additional three consultants, an improved nursing model, multi disciplinary co-ordination and improved pathways from ED to other specialties all contributed to patient's progress through the department. The department had been re-designed to allow patients to be treated in the most appropriate part of the department. The department was divided into an initial assessment area with ten treatment bays, a major's area with 22 bays and a resuscitation area with eight bays. A minor injuries and illness area with six bays was adjacent to the main department was open until midnight. The service was staffed by GPs and an advanced nurse practitioner employed by the trust. Medical staff from the emergency

department supported the minor injuries area when needed. Consultant medical staff could admit patients to the EDDU next door to ED if patients required further investigations or assessment but were likely to go home later that day or the next day. Admission pathways to other specialties had been reviewed and improved. One consultant specialised in intensive care and emergency medicine and was able to advise ED staff on the most seriously ill patients and facilitate their admission to ITU if appropriate.

- A nurse assessed patients arriving by ambulance or on foot, and then triaged them within according to the severity of their condition. Patients arriving by ambulance were seen by a nurse or a doctor in an initial assessment area before being transferred to the major's area with 36 bays. There was an isolation bay for treating patients with a condition, which might be transferable to other patients. A separate area was provided for assessing and treating children. A room was provided for teenagers to been seen, providing privacy.
- The percentage of emergency admissions via ED waiting between four and 12 hours had improved and was consistently less than the England average. The percentage of patients who left the department without being seen had reduced from 2.8% to 2.1% which was a considerable improvement. The numbers leaving has continued below the national average since May 2015.
- The proportion of patients being seen within four hours had improved from 93% to 95% in February 2015 and was being sustained. The work of the department had been transformed to ensure the achievement of national standards was sustainable and patients needs fully met whether they presented with acute trauma, required support from mental health services or needed overnight assessment on EDDU before going home. This had also been achieved by working with clinical colleagues across the hospital to introduce a new model of medical care which involved resulting in improved pathways for prompt admission to the appropriate specialty and consultant physicians in ED to assess and diagnose patient's condition. A consultant also worked in ITU and ED to treat critically ill patients and enable their safe transfer to ITU when required.
- Patients were assessed when they first arrived in the department by ambulance or on foot and streamed according to the severity of their condition. Patients we spoke with were positive about the initial assessment process. However some were unhappy about the time they had to wait before being treated and felt this was not fully explained by staff.
- Multi disciplinary review meetings were held four times during the day to review patients needs and the operational management of the department. One of the meetings was held at 10pm which ensured staff were managing the flow 24 hours a day.
- Waiting times in the department were on display in the waiting room although several patients told us they did not understand why they were seen so quickly when they arrived but had to wait for their treatment.
- An initial assessment was provided for patients with a nurse led assessment service. An ED consultant was available to support the assessment service if required. This meant patients investigations could be ordered to speed up diagnosis and treatment. Patients could also be fast tracked to the resuscitation area if their condition was more serious.
- The children's ED area had been decorated by an artist to provide a child friendly environment. One child we spoke with said "I like the monkeys and the lego on the walls." The young person's parent said, "We got through quickly with a bump on the head."
- The results of the CQC 2014 A&E survey found patients waited about the same as patients in other hospitals before they were handed over by ambulance crews to ED staff and about the same length of time before they spoke to a nurse or doctor.
- We observed five patients receiving treatment in the purple assessment area. Nursing staff introduced themselves to the patient and there was a comprehensive handover from the ambulance crew.
- The service monitored ambulance turnaround times and a standard operating policy was in place if significant turnaround delays developed. The procedure allocated additional staff to the purple area or transfers out of the department to free up space in the blue area to make space for patients.

# Urgent and emergency services

- We spoke with staff from the ambulance service who spoke highly about the department. They said, “It is a lot better than it was two years ago. Staff are flexible and helpful and when we arrive we feel noticed when we arrive and listened to”.
- .A patient who had attended on multiple occasions with severe illness told us that the department, " had been like a warzone and had improved a lot: ‘
- ED staff met four times a day to review how the department was operating. The number of patients was discussed and staff were allocated to areas of the department according to the severity of patient’s condition. Issues elsewhere in the hospital, which could have an impact on patient flow through the ED, were also discussed. For example the number of beds available in other specialties or problems with accessing portering or pathology services. Patients who were particularly ill, those where there were any safeguarding issues, patients awaiting psychiatric assessment, staffing, the number of beds available and waiting time breaches were also included in the meeting.
- The department had developed a point of care service to undertake a range of tests in the department and reduce the time for obtaining results. We saw a room had been newly equipped and the service was close to commencing. Patients would receive a more responsive service once the service began.
- Patients in the department for more than four hours had a tissue viability assessment completed and we saw the matrons check that these were being completed.
- The department had a process in place for identifying patients with sepsis. We saw examples of assessments that had been correctly completed. However, we found one patient did not have a completed assessment despite the person having being identified as having acute confusion and reduced levels of consciousness together with a high heart rate. The person had not been identified as possibly having sepsis despite staff having identified and recorded more than two potential signs of sepsis

**Learning from complaints and concerns**

- We spoke with one patient who told us they had complained about their experience and felt the complaint was handled very well. They said staff had been, “Very candid about the things which went wrong and I felt staff listened to my concerns”.
- We saw an analysis of complaints from April 2014 to October 2015, which showed the number of complaints had reduced month on month. The majority of complaints at our previous inspection followed particular themes such as poor communication processes, waiting times and lack of access to food and drinks. At this inspection we found the service had learned from these complaints for example senior nursing staff were spending more time in the department making sure patients were being offered food and drinks. Senior nurses had also received customer care training, which they said had helped them communicate and engage with patients and their relatives. At this inspection we found complaints were less focused around major themes and were more concerned with the individual circumstances of the patients visit. We saw examples of complaints and compliments sent to the trust via the “Ask Andrew” system. This was a facility on the trusts website, which allowed members of the public to email complaints and comments directly to the trust’s chief executive.
- The ED service monitored the number of complaints and these were compared to other services within the trust and historically over time. We saw a summary of changes, which had been made following investigation into complaints. A system was in place for ensuring these actions had been put in place. We saw examples of actions taken by the department in response to complaints. For example customer care training had been provided for senior nursing staff and there were plans to extend this to other staff. A system had been developed for recalling patients if an abnormality was found on an x-ray after the patient had been discharged. New vending machines had been installed in the waiting area following a complaint from a patient.

# Urgent and emergency services

## Are urgent and emergency services well-led?

**Outstanding** ☆

We rated emergency services at Wexham Park hospital as 'Outstanding' for 'Well-Led' because:

We found the department had been transformed over the last twelve months. When we previously inspected this service in February 2014 we rated this service as requires improvement overall and inadequate for responsive. Patients, staff and other services working closely with the service all told us things had improved significantly over a short period of time.

Since our last inspection a new leadership structure had been developed. Consultant medical staff provided leadership for aspects of the service such as clinical safety and patient experience, clinical governance, education and training. There had also been changes to the senior nursing team with the appointment of matrons who oversaw the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for.

Staff spoke positively about the considerable changes that had taken place over the last 12 months and the pace at which this had been achieved. They told us the leadership of the department provided clarity about the vision for the service and senior medical and nursing staff provided support and direction. Consultant medical staff had highly visible leadership responsibilities for improving the quality of service which staff believed was making a positive difference. Staff told us they felt more motivated, supported and energised and many told us how proud they were to work in the ED because the leadership and culture had improved. We observed staff who were confident about their roles and how to work effectively as a team. Staff were nominated for recognition of their contribution within the department, several had received awards within the trust and during our inspection one person received a national award for the work they had done on domestic violence.

Staff looked for opportunities to involve patients for example by inviting them to review patient information leaflets and involving representatives in the governance of the department through taking part in the clinical governance group. Staff told us how much things had improved over the last 12 months. They described how they felt more involved in developing the strategy for the service.

The department had made significant improvements to the service provided. There had been improvements in clinical practice and waiting times. Everyone we spoke to inside the department, including patients, staff working elsewhere in the hospital and partner agencies told us that the service had improved.

We spoke to the senior management and clinical teams and it was clear there had been strong and effective leadership to drive the changes forward at a considerable pace. The clinical, nursing and managerial team had worked closely with staff to develop a clear vision of what a good service should look like.

### Vision and strategy for this service

- Staff spoke positively about the considerable changes that had taken place over the last 12 months and the pace at which this had been achieved. They told us the leadership of the department provided clarity about the vision for the service and senior medical and nursing staff provided support and direction.
- Consultant medical staff had highly visible leadership responsibilities for improving the quality of service which staff believed was making a positive difference. Consultant medical staff had additional leadership responsibilities for particular area for example clinical governance, training and education. Staff told us they felt more motivated, supported and energised and many told us how proud they were to work in the ED because the leadership and culture had improved.

### Governance, risk management and quality measurement

- There was a well-developed system in place for managing governance, risk management and service quality. Monthly quality 'dashboard' reports had been developed which summarised information on performance against key quality standards such as four hour waits and ambulance turnaround times. Information was also included on a range of other

quality indicators. For example, the number of falls, hospital acquired pressure sores, time taken for a head injury to receive a CT scan, medicines errors and complaints

- .A Clinical Governance group was the main forum for bringing the strands of clinical quality together. The ED quality dashboard reports were discussed by the department's Quality Committee.
- .The group was led by the ED consultant with responsibility for clinical governance. The minutes of the meeting showed senior clinical staff from other specialties attended most months to discuss specific items relevant to the work of the ED. For example, a consultant haematologist discussed the results of an audit for chemotherapy patients who developed sepsis and a pharmacist discussed the trust's updated policy for antibiotics.
- The remit of the clinical governance group covered a wide range of issues, including incidents that had occurred in the department; the results of national clinical audits; clinical guidelines; the results of the friends and family test; and complaints and compliments. The actions taken in response to issues discussed at previous meetings were also monitored to ensure the changes agree had been embedded into practice.
- Monthly clinical governance and incident newsletters were circulated widely throughout the department and posted to staff's email accounts. We found the structure and accountability arrangements for clinical governance in the department were clear and well understood.

**Leadership of service**

- The department had experienced considerable change since our last inspection, which had been delivered quickly. The fast pace of change had been achieved through the engagement and leadership of senior clinical staff focusing on quality improvement. The senior clinical leadership team led improvements within the department and worked with colleagues in other clinical departments to develop a medical model, which had improved patient flow through the emergency department.
- Matron's roles had been appointed who were visible in the department. The matrons provided staff supervision and support, and ensured patients were being well cared for. Staff and patients were clear who was in charge and knew who to go to for advice. The Matron's identified issues early and acted to resolve them.
- Consultant medical staff told us they had received coaching support, which had given them greater insight into their leadership skills. They said this had helped them reflect on the role they could play in leading change and how to make sure the ED team felt engaged and empowered.
- We saw the notes of a meeting in May 2015, which had been organised to review the department's development objectives. These notes of the meeting showed the department had acted on the issues identified at our previous inspection. For example key safety goals were identified which included the timeliness of patients medicines, access to clinical guidelines and safeguarding training for medical staff. There was a clear action plan for the issues identified.
- Senior leaders from the department participated in monthly urgent care steering board meetings alongside colleagues form other specialities to discuss pathways between departments. The group also discussed improving access to ED with the ambulance services.
- There was strong leadership forof governance within the department. There was multi-disciplinary team working involvingbetween medical and nursing staff. Other clinical professionals for example occupational therapists were also involved in multi-disciplinary meetings. Monthly meetings had been established with other speciality teams that also included patient representation. Consultant medical staff had taken on leadership roles for CQC domains of safety, effectiveness, responsiveness, caring and leadership.

**Culture within the service**

- Senior medical staff told us about the work that had been undertaken within the department to develop leadership and address issues which had been raised at the previous inspection. They said an external facilitator had been working with the department and the leadership team. Staff told us the department had developed a 'can do' approach because of the work.
- Staff were encouraged to challenge each other if they felt something was unsafe. We saw an example of an

incident where a member of staff had been praised because they had appropriately challenged a colleague and prevented an error occurring. A member of the junior medical team told us a major plus of working in the department was the teamwork and the culture. They said they had returned to work in the department after working in another branch of medicine because of the positive culture. They said they would recommend the department as a place to work. They said the support they received from senior medical staff was excellent resulting in an environment where openness and learning was encouraged.

- A nurse who had returned to practice after an absence of five years told us they had applied to work at Wexham Park because of the hospital's reputation. They said they felt valued and were confident they could challenge senior nurses and medical staff.
- All the staff we spoke with described a culture of openness where they could raise issues and challenge without fear. Where errors occurred staff felt there was a 'no blame' culture and staff were eager to make sure they learned from their mistakes.

### Public engagement

- A patient we spoke with told us they were pleased they had been assessed quickly when they had first arrived in the department but they said, "I don't understand why I have been waiting over an hour now to be treated." They said, "I know I can text feedback on the hospital and I could use it to make a complaint and I am pretty confident I would get a response." Staff had met in February 2015 to discuss the issues raised by patients which included ways of improving people's privacy, patients not understanding the differences in waiting times in different parts of the department and patients not feeling fully involved in discussions about their care and treatment. A range of ideas and actions to address the issues had been discussed some of which had been implemented at the time of our inspection for example the time patients were likely to wait for treatment were displayed in the waiting area.
- A patient representative participated in the ED clinical governance meetings. The Clinical Governance group was the main forum for bringing the strands of clinical quality together.

### Staff engagement

- We saw from records of meetings that safety improvement had been discussed at a meeting in January involving all staff working in ED including volunteers, portering and clinical teams. The group had carried out a safety survey questionnaire amongst staff to identify top areas to focus on. A safety culture survey had been undertaken in March which showed 76% of the staff who responded understood how to report patient safety concerns
- Staff were involved in discussions about the service improvement. Groups had been set up following our last inspection to address the issues raised. We saw staff had been asked what they felt worked well and to make suggestions for improvement. The service had implemented these recommendations, which had led to improved performance.
- A new Chief of Service had been appointed to lead the ED at Wexham Park hospital. A Deputy Chief of Service had also been appointed with leadership responsibility for the service at Wexham Park.
- Staff told us they were also involved in design of the new emergency department being planned by the hospital to open in 2016

### Innovation, improvement and sustainability

- The service had re-designed the department to improve patient flow and consistently achieve national waiting time quality standards. The department had achieved the four hour waiting time standard since February 2015. Patterns of attendance had been analysed and staffing levels were adjusted to respond to changing demand patterns. This meant staff were more able to respond to potential breaches and reduce the risk of these occurring.
- Groups had been set up to review how the department performed against the CQC standards.
- A consultant with responsibility for leading on mental health had set up regular meetings with the psychiatric liaison manager to improve the service for patients in ED.
- Single clerking document launched in August 2015 to reduce duplication of paperwork by inpatient team doctors thus releasing more clinical time.

# Urgent and emergency services

- Waiting and reporting times for x-rays were reviewed jointly by ED and radiology staff to ensure patients were not waiting longer than necessary for x-rays.
- The department had worked with colleagues form other specialties to increase the services available for patients during the winter months. This had helped maintain the flow of patients through the department and improve waiting times. There were plans to put similar arrangements in place for the forthcoming winter period.

# Medical care (including older people's care)

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Medical care services at Wexham Park Hospital are managed by the Medical Directorate.

The Medicine Directorate consists of the following clinically led specialties: Cardiology; Respiratory; Acute Medicine; Gastroenterology; Diabetes and Endocrinology: Rheumatology; Care of the Elderly; Stroke; Haematology; Oncology; Dermatology Neurology and Nephrology. The directorate also manages the discharge lounge.

During 2014 there were 27,437 medical admissions, 65% of which were emergencies and 33% day cases. The majority of admissions were in the specialities of General Medicine (67%) and Gastroenterology (27%).

Medical care services had a bed compliment of 370 beds over 11 wards and 2 other clinic areas, including an oncology day unit. During our announced inspection we visited all the medical care areas managed by the directorate and the discharge lounge.

To help us understand and judge the quality of care in medical care services at Wexham Park Hospital we used a variety of methods to gather evidence. We spoke with doctors, including consultants, registered nurses, including ward matrons, and healthcare assistants. We also spoke with allied health professionals and support staff, such as domestic staff. We interviewed managers. We also spoke with about 30 patients and their relatives. We looked at around 20 sets of patients' health records.

We observed care and the environment and reviewed a wide range of documents including audit and investigation reports, action plans, policies, and management information reports.

# Medical care (including older people's care)

## Summary of findings

Overall we rated medical care (including elderly care) at Wexham Park Hospital 'Good' because:

- We found medical care at the hospital was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The hospital was able to demonstrate that it mostly met national quality indicators.
- Patients' medical outcomes were monitored and reviewed through formal national and local audits. Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety.
- We found that the hospital was working towards offering a full seven-day service. Although some medical patients were treated in other areas of the hospital when beds were not available, systems had been put in place to ensure the consistent quality of their care. Staff responded to individual patient needs for those living with dementia.
- The hospital had systems in place to allow patients to feedback their experience of care on the medical wards. The results of the surveys indicated that the department provided excellent, compassionate care by friendly and approachable staff. Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. Complaints processes had been improved since our last inspection. Complaints were acknowledged, investigated and responded to appropriately.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

- We found some paper health records to be large in size and documentation was hard to locate in these records easily.
- The electronic prescribing system used for patients requiring chemotherapy could not be accessed by staff working in Emergency Department (ED). Although staff had put in measures to mitigate this risk the trust may wish to reassess the risks associated with these measures.
- There was an overdependence on agency staff to support permanent staff to ensure safe staffing levels during the delivery of chemotherapy.

# Medical care (including older people's care)

## Are medical care services safe?

Good

We rated the medical care (including elderly care) at Wexham Park Hospital 'Good' for 'Safe' because:

We found that the trust had made improvements in patient safety since our last inspection.

There were now robust systems to monitor safety throughout the service. The directorate understood risks, had a clear picture of safety across services and was focused on improvement. Staff took an active role in delivering and promoting safety, learning and improvement. When things went wrong staff were open and transparent with those affected.

The trust had improved recruitment and retention of staff. Staffing establishments were set, and actively reviewed to ensure patients' needs were met.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

Although medicines management had improved there still remained areas which required improvement. We found oxygen cylinders did not consistently have expiry dates and ward nurses were not always signing receipt of medications when they were delivered to the wards.

The electronic prescribing system used for patients requiring chemotherapy could not be accessed by staff working in the Emergency Department (ED), although measures had been put in place to mitigate this risk the hospital may wish to review this.

### Incidents

- During the period October 2014 to September 2015 the medical directorate reported a total of 19 serious incidents (SI) and no never events (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented).The SI's included 10 slips/trips/falls, five pressure ulcers, three unexpected deaths and one incident classified as unknown.
- The risk teams had revised reporting processes so both trust sites (Wexham and Frimley Park) were using the same reporting criteria. Staff who spoke with us on the medical wards demonstrated their knowledge of the incident reporting system. All staff were aware that incidents should be reported and were able to use the electronic reporting system. On the wards we visited we saw a 'Datix Trigger List' poster which reminded staff of the importance in reporting incidents.
- It was of note that of a total of almost 600 incidents reported during the period, only 23 were reported by medical staff. This indicated that, whilst all medical staff we spoke with were aware of the system, there may be less clarity on what incidents should be reported and by whom.
- We saw that agency nursing staff used the incident reporting system.
- We saw evidence that robust systems were in place to discuss incidents with operational staff to support learning and improve practice. We were told by a matron that incidents were discussed at staff meetings and junior and senior sisters' monthly meetings. All minutes from the staff meetings were emailed to staff and placed in a folder in the sisters' office which was easily accessible. We saw staff meeting minutes which confirmed that incidents, such as falls, were discussed and staff were involved in the remedial actions to improve clinical practice. One matron we spoke to told us that the sharing from SI investigations and learning had greatly improved since our last inspection.
- Copies of the September 2015 Clinical Governance Newsletter and the Patient Safety and Quality (PSQ) Newsletter were found in clinical areas across the trust. These newsletters reinforced the importance of reporting incidents along with changes in practice that the trust had made to reduce the number of serious incidents. For example, in the PSQ newsletter under Venous Thromboembolism (VTE) risk assessments it stated, "Complete the VTE risk assessment form and put the stickers on the patients' drug charts". We saw that this had been implemented in the patient records looked at during the inspection.
- We reviewed the minutes from the multidisciplinary Respiratory Clinical Governance Board meetings and

found incidents were openly discussed. A clinical governance action log was completed at the end of the meeting and reviewed monthly giving an audit trail of actions to improve practice. Learning points were fed into the Corporate Clinical Governance meetings where SI investigations were presented.

- The Eden day unit sister told us that adverse incidents were recorded in the electronic reporting system as well as informing the lead chemotherapy nurse. Incidents reported included falls, extravasations (accidental administration of intravenously infused medications into the tissue space) and medication errors. Reviewing the data submitted from the trust, 59 oncology incidents (covering the day and inpatient areas) were reported in the last 6 months demonstrating there was a culture of reporting.
- We found evidence of action, learning and changes in practice from a recent root cause analysis investigation of an SI on the Eden Day unit.
- Monthly medical professional meetings took place where all band 6 and 7 staff attended. All incidents, SI's, action plans and staff vacancies were discussed along with what was going well and what required improvement.
- We saw that robust systems were in place to manage safety alerts. A junior sister told us that they received an email from the lead nurses, pharmacy or the equipment department to highlight concerns. Equipment where issues had been identified on an alert would be removed from the ward.
- The trust had set up a Mortality Review Group (MRG) that took place monthly and reported to the Quality Committee. The MRG reviewed the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) data and worked with clinicians to use the data to improve practice. A summary was provided to the board highlighting any changes in SHIMI and HSMR data. The mortality leads screened all the deaths at Wexham Park using a screening tool which flagged up deaths that required a deeper review. This also helped to support doctors in training where a patient had died. One improvement in practice reported since introducing the MRG was better completion of Medical Certificates of Cause of death (MCCD).
- Each medical speciality held mortality and morbidity (M&M) meetings monthly where all deaths are reviewed. We looked at the minutes from the respiratory M&M meetings from the last 6 months and saw that discussions had taken place. The structure of the M&M process differs from the Trust Development Agency (TDA) recommendations but was thorough, structured and proportionate. We saw there was multidisciplinary attendance at the meeting, but it was not clear whether junior doctors attended the M&M meeting which could reduce opportunities for junior doctors to learn from patient deaths.
- Staff we spoke with were aware of the duty of candour regulations. A matron we spoke with told us that this was incorporated in the incident reporting system and prevented an incident from being closed down until the duty of candour process was completed. We were told that a case manager facilitated family case meetings and we saw family meetings were logged in the medical records.

**Safety thermometer**

- All clinical areas participated in safety thermometer reporting and the results were visible at the entrances of the wards on the "Safety and Patient Experience" board. We saw evidence that safety data was being collected regularly. This informed staff, patients and visitors how long it had been since a fall with harm had taken place, number of days since the last pressure ulcers reported, hand hygiene and cleaning score on the ward. On one ward we visited it had been 89 days since a fall with harm and 193 days since a pressure ulcer was reported, hand hygiene was 95% with the cleaning score at 98%.
- We saw that safety thermometer information related to individual wards in order that local trends could be identified and comparisons between areas made to improve care. Between June 2014 and June 2015 a low number of falls and pressure ulcers had been reported across the medical wards. On one ward we reviewed the safety thermometer data for 2 September 2015 and found 21 out of 24 harm free patients with no new falls and pressure ulcers reported. However, on that day two urinary tract infections (UTI) had been identified, one with and one

without a catheter. This demonstrated evidence of continuous monitoring and management to improve patient care and reduce occurrence of infections and other incidents.

- Falls with harm between April 2014-2015 showed that 16 had been reported. Most of the wards we visited demonstrated a decreasing trend. Patients at risk of falling were given green wristbands and wore red socks so staff were able to easily identify them. The trust had introduced falls alarms. Other falls prevention methods included medication reviews and for patients over 65 having lying and standing blood pressure taken on admission to highlight if falls in blood pressure were putting patients at risk of falling. The trust was promoting 'fall champions' in clinical areas.

- Patients were assessed for the risk of developing a venous thromboembolism (VTE) on admission as well as being reviewed 24 hours later, or if the patient's condition changed. The patient medication chart contained a sticker identifying that a VTE risk assessment had been performed with a section for documenting the VTE score and prescribing prophylaxis such as anticoagulants and anti-embolism stockings
- Between November 2014 and October 2015 the directorate had completed an average of 95% of VTE assessments on admission which met with their target of 95%.

**Cleanliness, infection control and hygiene**

- At the last inspection, patients and relatives had stated that the hospital and wards were unclean. We found a marked improvement at this inspection. We observed that the wards were visibly clean and well maintained. We saw support staff cleaning the wards throughout the day and following a daily works schedule. We were told by a matron we spoke to that environmental audits were performed in conjunction with the nurse in charge. The levels of cleanliness were checked including chairs, corners, under beds and high dusting. We observed an audit being undertaken on Ward 9 during the inspection.

- There was a system of infection control and hygiene audits. The average score for medical wards for audits carried out in Q1 of 2015/16 was 97%. Cleaning audits were also performed and medical wards achieved an average score of 97% for the period February - July 2015.

- The wards we visited had a range of equipment that was seen to be visibly clean. There was a system of "I am clean" labels to indicate an item had been cleaned and was ready for use.

- At the entrances to the wards and inside the nursing bays and single rooms we observed adequate hand-washing facilities. The bare below the elbow policies were seen to be observed by all staff. Staff were able to tell us about the five World Health Organisation (WHO) steps to good hand hygiene.

- We observed staff wearing personal protective equipment (PPE) including disposable gloves and aprons and washing their hands between each patient contact.

- On the wards we visited there were side rooms available to undertake isolation/barrier nursing. A notice on the door highlighted to staff and visitors about the additional precautions required when visiting the patient. We observed staff and visitors on the Acute Medical Unit (AMU) wearing different coloured disposable aprons when caring for these patients. Staff told us that this was a reminder to all of the increased risk and the importance of following good infection control practices to prevent further spread of infections.

- The sister on Ward 3 told us that that all relatives were shown the precautions required before visiting a patient in isolation and the trust infection control nurse visited the ward daily or weekly as needed. They provided drop in sessions to keep staff updated in infection control practices to prevent and control the rate of infections, including hospital acquired infections.

- Between June 2014 and June 2015, the trust reported no cases of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia; however 18 cases of Clostridium Difficile (C. diff) were reported. On Ward 3 we observed a patient with C. diff was being nursed in isolation according to trust policy.

- At all entrances to the wards Patient and Safety Experience boards contained information that was updated weekly. This gave details including the hand hygiene compliance rate and the number of days since the ward had been methicillin resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C. diff) free.

**Environment and equipment**

- The medical wards we visited were arranged with bay areas and separate single rooms. Single rooms were used to manage patients with certain infections and those requiring end of life care. Staff had separate storage areas for clinical equipment. Staff we spoke with told us that, "The environment was now much better." On Ward 9 the sister told us that a recent environmental audit had been undertaken which highlighted very poor decoration, leaking, mould and cracks on walls. The patients were transferred to another ward while the ward was refurbished ensuring patients were being cared for in a safe and healthy environment.
- On Ward 17 we observed the flooring was of poor quality. This had been identified by a consultant and the charge nurse who raised it as a hazard and risk to dementia patients. The issue had been escalated to estates and the senior management team, however staff were still awaiting information on how the hazard was going to be managed.
- Resuscitation equipment was easily accessible in all the medical wards. We saw that logs were kept on each trolley to show they were checked daily and ready for use as per trust policy. We found that on several wards, including Wards 3, 9 and the Eden unit, that oxygen cylinders did not contain an expiry date.
- Arrangements were in place to service equipment. We saw that the hospital kept a log of all their equipment which included information such as the model, supplier, condition of equipment, and when it was due to be serviced or replaced. On one ward we visited we observed a supply of blood pressure machines all of which contained in date service records and 'I am clean stickers'. Staff told us they had enough equipment to enable safe and effective delivery of care.

**Medicines**

- On several wards we visited we checked the storage facilities and record keeping of the medicines and intravenous fluids (IV's). We found that correct procedures were followed and records were maintained in accordance with regulations and legislation. However, we did observe on Ward 9 that when new medicines arrived on the ward the receipt was not signed by a member of staff which meant there was no audit trail that medicines had been appropriately checked into the ward.
- Medicine trolleys were chained when not being used and stored in the treatment rooms which had a digital lock to prevent unauthorised entry. Medicines which were temperature sensitive were stored appropriately and regular checks were made of refrigeration and ambient temperatures.
- We checked the storage of controlled drugs (CD's) and found they were stored securely and handled appropriately demonstrating compliance with relevant legislation. CDs were regularly checked by staff. We audited the contents of the CD cupboard against the CD register on two wards and found they were correct.
- We reviewed three medicine prescription charts on Ward 3 and observed they were completed clearly, were legible with known allergies noted. We looked at two other medicine charts on other wards and noted that where a medicine had not been administered staff had included the code that identified the reason for the omission.
- We observed that Venous Thrombolisation (VTE) assessments had been performed and a sticker was placed on the chart to signify this, an improvement since the last inspection. We found that oxygen was prescribed and on one prescription chart a five day course of antibiotics had been prescribed with a review date in place. We also saw clear documentation of antibiotics being stopped and the reason for this indicating that staff were following the trust antibiotic policy.
- We observed that staff were following good practice in line with the National Dementia Strategy 2009 guidance and use of anti-psychotics for people living with dementia 2009 guidance when prescribing

anti-psychotic medication. In one medication chart we reviewed, we saw the appropriate medication prescribed as needed. The rationale for the administration was provided.

- On the Eden Day unit we found that chemotherapy that was delivered to the unit was stored in the treatment room which had a digital lock on the door to prevent unauthorised access. The storage of all other medications followed national guidance.

**Records**

- The trust used paper medical records which resulted in some patients acquiring large sets of medical notes which were not easy to navigate to find the information required.
- We observed in several sets of medical notes we reviewed that after a clinical entry the name, designation, date and General Medical Number (GMC) were not always clearly written making it hard to establish who had reviewed the patient.
- On the Oncology ward and day unit staff used a combination of paper and electronic medical and nursing notes. An Oncology Electronic Information System supported chemotherapy prescribing, drug ordering and pharmacy dispensing. Staff within these areas had received training and passwords and used the system to input patient information pre and post oncology treatments. This information however could not be viewed by staff on the medical wards should a patient be admitted during the night. To mitigate this situation nursing staff on the chemotherapy units had been asked to update patients' medical records to ensure that patient records were complete, accurate and up to date.
- We checked five sets of medical notes at Wexham Park for patients receiving chemotherapy and found that no updates had been recorded by the nursing staff following patient treatments on the day unit, but on the ward we observed that nursing notes were being completed. Patients had chemotherapy diary record books which we saw were completed by the nurses at the end of a chemotherapy treatment.
- Staff in the Emergency Department did not have access to the electronic prescribing system used for oncology patients**.** However, we were told the department could contact Eden Day unit and the ward overnight for access to information from trained staff. At times of high activity, this may introduce a level of risk for the patient.
- We reviewed 15 sets of medical notes across a variety of medical wards. We found good labelling/patient identification. There were frequent consultant reviews that took place within 14 hours of admission and typically every 24 – 48 hours.
- Two sets of notes did not have a completed pathway for acute kidney injury (AKI).

**Safeguarding**

- Almost 100% of nursing staff across the medical directorate had completed their safeguarding training levels 1 and 2.
- Staff were able to demonstrate an understanding of the safeguarding of vulnerable adults and the Deprivation of Liberty Safeguards (DOLS). They were able to describe the escalation process required to raise a concern.

**Mandatory training**

- We found mandatory training was predominantly annual and a mixture of study days and e-learning. Some training took place every two or three years. A matron we spoke to told us that yearly training included infection control, manual handling, fire, information governance training and basic life support. Three yearly training included dementia and safeguarding. Training was modelled around the duties of the different staff groups to ensure patient safety.
- On one ward we visited we saw evidence that mandatory training rates were about 90%. On a second ward we visited we saw training records confirmed that nearly all staff had completed their mandatory training.

**Assessing and responding to patient risk**

- The nursing notes we reviewed contained risk assessments, which we saw had been completed when patients were admitted to the wards. The assessments included moving and handling reviews, risk of developing pressure ulcers, bed rail assessment, falls assessment and nutritional

assessment. Staff on two wards we visited told us risk assessments were updated if circumstances changed and reviews were conducted if patients remained in the hospital for long periods. This was evidenced in the nursing notes we reviewed.

- Patients' vital signs such as temperature, pulse and respiration rates were recorded. The early detection of deterioration scoring tool (EDOD) was used and had clear guidance and trigger points to alert staff when to escalate care. The weighted scoring system allowed a graded response. In the medical records we reviewed we saw good evidence that EDOD was being implemented with care being escalated in accordance with triggering scores and guidance.
- The hospital audited its compliance with EDOD. The last audit we were able to review data for was 2014. The publication of 2015 data was due to be published in June 2016. The 2014 audit highlighted good compliance with all standards exceeding the 90% target. However, there were some wards and areas with significantly lower compliance. Following the audit the trust made changes to improve staff awareness. This included EDOD training during induction and as part of the essential training programme. The results of the audit were presented at the Patient Safety Group, the Clinical Effectiveness Group and speciality and directorate Governance meetings.
- The Intensive Therapy Unit (ITU) outreach team monitored EDOD and supported the ward with deteriorating patients. If a patient needed to be admitted to ITU this was done in conjunction with discussion with a consultant. The aim was to admit the patient within four hours. However, we were unable to confirm if all patients requiring admission to ITU were admitted within the four hour standard.
- The senior nurse told us that systems were in place to support a patient who might suffer a reaction to chemotherapy. These included immediate access to medical staff on the Eden unit from the Eden ward.

**Nursing staffing**

- The numbers of staff planned and actually on duty were displayed at ward entrances in line with guidance contained in the Department of Health document "Hard Choices". However, whilst we saw that the nursing levels for the day did not always have that day's date staff told us that the boards were updated daily.
- Nursing staff vacancies were evident on the majority of the medical wards we visited. On two wards we visited there were 16 Registered Nurse (RN) vacancies. A matron we spoke to told us that the close proximity to London made recruitment difficult as well as poor recruitment of student nurses in the past. To address these concerns the trust had introduced some innovative recruitment strategies such as a "golden hello package" and "recruit a friend scheme" to encourage staff to come work at the trust.
- The trust had a recruitment strategy that was addressing the nursing vacancies. This included monthly open days and career fairs, attendance at national and regional job fairs and revised benefits packages.
- Student nurse recruitment had markedly increased this year to 32 from the previous year where only four were recruited. We were told that students could enlist on an "acute rota programme" during preceptorship where they would gain experience in clinical areas such as cardiology, respiratory, Accident and Emergency (A&E) and the Acute Medical Unit (AMU). We were told 16 registered nurses had signed up to the programme.
- We saw on Wards 3 and 5 that staffing levels had been placed on the ward risk registers.
- Staffing levels were monitored through the directorate clinical governance meetings and the Patient Safety Group as well as the daily staffing meeting attended by the senior nurse.
- There were three daily bed meetings where staffing levels across the wards were updated. This enabled management of staff throughout the day and opportunities to take action where staffing issues were identified. Any shortages of staff were discussed and managed to ensure safe staffing levels were in place across the wards. One matron we spoke with told us that staff acuity was used to maintain safe staffing levels and one sister we spoke with said that any staffing issues were escalated to the matron at the time it was identified.

- Electronic staff rostering was used to plan staffing for a six-week period and senior sisters identified the shifts needing to be covered in advance in order to meet vacant posts and long-term absence. These were then checked by the matron and Head of Nursing. A nursing sister and health care assistant we spoke with told us that they worked extra shifts to help provide the required cover. Any deficits in the rota were filled by NHS Professionals (NHSP).
- We reviewed the nursing staffing returns for the month of June 2015. We saw that daytime fill rates (to meet agreed staffing templates) for registered nurses ranged from 85 to 106% for medical wards. For day time care staff the fill rates ranged from 80 - 127%. For nights the registered nurse fill rate was 75 - 103% and for night care staff it was 80 - 150%. This shows there was variability in fill rates, although these figures do not take account of occasions when a ward may run below agreed numbers due to decreased patient need.
- On Eden Ward we saw that agency staff had a passport. The passport identified the areas of training required before they worked a shift on the ward and included, for example, identification checks, local orientation and medicines management. We saw 20 completed passports during the inspection. On Ward 9 the matron told us that they had a regular base of four agency nurses who knew the ward and provided continuity in care.
- Agency staff were used when NHSP was unable to cover a shift. We saw evidence of the personal files of the agency staff that regularly undertook shifts in the Eden day unit. The files included copies of their curriculum vitae, professional qualifications, training undertaken and references. Induction training was undertaken and we were told that passwords were given to enable agency staff to access real time documentation.
- On the Eden day unit staff told us that six vacancies existed which included five band 5 RN's and one band 6 RN. Six substantive RN's were in post. When operating two chemotherapy day units each Tuesday and Wednesday, concerns were raised that insufficient staff numbers placed added pressure on staff which resulted in a poorer patient experience including extended waits. Patients we spoke with confirmed they often had long waits to receive their treatments but accepted it as staff were very busy and rushed.
- We reviewed the nursing staff rotas for the chemotherapy day service and saw that in July /August 2015 there were 25 agency and four NHSP shifts. In August/September 2015 this had increased to 35 agency with three NHSP shifts. There was an overdependence on agency staff to support permanent staff across the day units to ensure safe staffing levels during the delivery of chemotherapy.
- Matrons told us that senior sisters undertook clinical work one day per week to support staff vacancies, as well as matrons who worked clinically when required. In addition, the practice development team were supporting the maintenance of safe staffing levels by working one shift per week on the wards.
- There was a senior nurse on site out of hours to support staff and was called upon should any issues or concerns arise. This meant that staff did not need to leave ward areas and could remain caring for patients.
- We were told that the Frimley Health NHS Foundation Trust sickness/absence policy had recently been introduced. This was a more robust policy than that previously in place and set out a framework on how sickness absence should be managed. On one ward we visited the sickness/absence level was 4%. The matron we spoke to told us that if a member of staff was sick NHSP were contacted and the staff member was unable to work a NHSP shift for the following two weeks.
- The acute oncology service had two vacancies for Clinical Nurse Specialists (CNS). This meant that patient and carers did not have access to specialist skills and support. The lead chemotherapy and matron nursing posts were vacant but were out to advertisement. There was a vacancy for a lymphedema specialist nurse.

**Medical staffing**

- Medical consultants were available to provide advice and support seven days a week. We saw evidence that

confirmed ward rounds took place at the weekend. Patient records we looked at showed that patients were reviewed by a consultant at least once every 24 hours.

- Consultant cover on weekdays was 8am-12pm post-take consultant, 12pm-8pm MAU (ambulatory care and admissions), 5pm-9.30pm Physician on call who covered admissions, handover and overnight off-site. There was additional on-call 5pm until 8pm Monday to Friday.
- Additionally there was a consultant of the week Monday to Friday on specialty ward areas (cardiology, respiratory, diabetes/endocrine, rheumatology, care of the elderly) who was available for advice/consultation. Gastroenterology were due to commence this service in September 2015.
- Additionally on weekdays there was specialty registrar cover 9am-9.30pm (admissions), 2pm-9.30pm (ward cover), 9pm-9.30am (admissions/ward cover), 9am-9pm (MAU). Along with GPST/foundation/core doctors covering 9am-5pm admissions (ST/CT/F2 x 1), 8am-5pm admissions/MAU (ST/CT/F2 x 1), 3pm -midnight admissions/MAU (ST/CT/F2 x 3), 9pm-9.30am admissions/ward cover (ST/CT/F2 x 3), 5pm-9.30pm ward cover (F1 x1), 9pm-9.30am ward cover (F1 x1). This meant that there was a minimum of three or four doctors (not on-call) per speciality ward.
- At Weekends there was a physician on call (admissions) 8am to 8pm Saturday and 8am to 4pm on Sundays, and a physician on call (MAU/wards) 8am to 6pm Saturday and 8am to 8pm on Sundays. There was an additional physician on call 3pm – 9.30pm (admissions, handover, overnight off-site).
- At weekends there was also a physician for cardiology ward round/referrals (on call when not on site) 9am until 1pm and a cardiologist on call (catheter lab, on call when not on site) 1pm-5pm on Saturdays and 9 am to 1pm on a Sunday. A physician for neurology referrals was available 8am until 9pm.
- During the weekends there was specialty registrar cover 9am-9.30pm (admissions), 9am-9.30pm (ward cover), 9am-9pm (MAU speciality doctor) and 9pm-9.30am (Admissions/ward cover). GPST/ Foundation/Core doctor cover over weekends was 8am-6pm MAU (ST/CT/F2 x 2), 9am-9.30pm MAU (ST/CT/F2 x 1), 9am-9.30pm ward cover (ST/CT/F2 x 2) ,3pm-midnight ward cover (ST/CT/F2 x 1), 3pm-midnight admissions (ST/CT/F2 x 2), 9am-9.30pm admissions/ward cover (ST/CT/F2 x 3), 9am-9.30pm admissions (F1 x2) and 9pm-9.30am ward cover (F1 x1).
- On Bank Holidays there were additional speciality ward rounds (one consultant per ward) 9am until 1pm.
- The hospital employed 137 whole time equivalent (WTE) medical doctors. This consisted of 33% consultants, 5% middle grades, 38% registrars and 24% junior doctors. This was in line with the England average.
- Emergency Haematology and medical cover was available at all times. However we were told there was no emergency oncological cover and if issues developed during the day on the wards there was no oncologist present to manage difficult care or treatment needs. Oncologists were based at Mount Vernon and Royal Berkshire Hospitals.

**Major incident awareness and training**

- The trust had a major incident policy in place. A matron we spoke with demonstrated a good understanding of the trust major incident plans and told us that action cards were available to describe their duties in the event of a major incident. A recent incident had occurred which resulted in all matrons being called to the operations centre to manage the incident. They were aware of how to access the plans and what their role would be or who would be responsible for directing them.
- The trust had designated Snowdrop ward as an escalation ward with eight medical beds. Snowdrop would accommodate any increase in admissions over and above what the other wards could accommodate in the event of a major incident. A senior nurse told us that staff from Ward 2 would be used to support Snowdrop when opened and Ward 2 would be backfilled with agency staff. At the time of the inspection Snowdrop ward was closed.

## Are medical care services effective?

# Medical care (including older people's care)

Good

We rated the medical care (including elderly care) at Wexham Park Hospital 'Good' for 'effective' because:

We found medical care at the hospital was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet.

The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The hospital was able to demonstrate that it mostly met national quality indicators. Patient medical outcomes were monitored and reviewed through formal national and local audits.

Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that the hospital was working towards offering a full seven-day service.

We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety.

Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink. Special medical or cultural diets could be provided.

**Evidence-based care and treatment**

- New NICE guidance and any speciality specific published guidance was discussed at clinical governance meetings. Specialities discussed their compliance with guidelines and identified any risks. This was a regular agenda item and was minuted.
- The Oncology and Haematology services followed the pathways and treatment regimens developed by the Thames Valley Strategic Clinical Network. This meant that patients were receiving care in line with national guidance. However, as oncologists came from two centers (Mount Vernon and Royal Berkshire Hospitals), staff had to manage different processes and procedures in the delivery of care which meant there was a risk of confusion and error.
- There were systems for benchmarking clinical practice against guidance. For example, clinical practice in using Tocilizumab for Rheumatoid Arthritis at the hospital between 2010 and October 2014 was compared against NICE guidelines (NICE TA247and BSR recommendations). This showed 100% compliance for indication, neutrophil monitoring and counselling and 92.3% for liver monitoring. However, fasting lipid profile monitoring at baseline and 3 months showed low levels of compliance (23% and 16%) this was mainly due to non-fasting lipid profile measurement. The hospital has made changes to this process and planned to re audit later in the year.
- We saw examples in records where care bundles had been triggered and followed in accordance with NICE quality standards such as acute kidney injury (AKI).
- All diabetes related adult guidelines were updated in August 2013. The trust was making further updates to the policy at the time of our inspection. The updates included guidance from the Joint British Diabetes Society in partnership with NHS Diabetes and NICE CG119, diabetic foot problems, (March 2011).
- The hospital operated a multidisciplinary diabetic foot service in accordance with NICE CG119. There was an in-patient pathway for diabetic foot with the hospital aiming to assess all diabetic foot admissions within 24 hours (Monday to Friday)
- The Gastroenterology unit operational policy incorporated local protocols and guidelines and was updated in May 2015. A Gastrointestinal (GI) endoscopy care pathway was used for each patient which included a detailed safety checklist based on the World Health Organisation's surgical safety checklist.
- In gastroenterology, we found there was a rolling audit programme for endoscopic procedures carried out at the hospital. 30 day mortality, 8 day readmission and timely follow up OGD for gastric ulcer were audited monthly. Results and any learning points were followed up at monthly clinical governance meetings and monthly user group meetings.

**Pain relief**

- Policies and guidance on pain management had been reviewed and inpatients were audited for their experience of pain.
- We saw that information on pain management was available to staff through the 'Pain Matters' newsletter.
- The hospital used a pain scoring tool to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.

**Nutrition and hydration**

- Patients were risk assessed for nutritional problems using the Malnutrition Universal Screening Tool (MUST), a nationally recognised tool. Further assessment and support from a dietician was available for those assessed as at risk of malnutrition.
- We saw from the notes that we looked at that patients had nutritional assessments on admission. These were reviewed appropriately and actions were taken according to any identified risks, such as referral to the dietitian.
- We found there were systems to ensure that staff were aware of patients' dietary needs and received any support required. On one of the wards we visited we saw that meal times were protected. Staff were alerted to this time by the ringing of a bell on another ward we saw the "red tray" system in place. Patients requiring support were identified on a whiteboard in the ward kitchen and staff informed at handover. Nursing staff assisted patients with eating. Where there was open visiting, for example on Ward 6, families also helped their relative with eating.
- We observed lunch on one medical ward during the inspection. Staff supported patients where required in a calm atmosphere. A patient we spoke with said that they were enjoying their lunch and that, "It's nice and hot".
- We received variable comments on the quality of the food from the patients we spoke with. If a patient was an inpatient longer than three weeks they could order their meals from the restaurant. This was confirmed by the dietician.
- We observed that hot and cold drinks were available with water jugs regularly checked and refilled. This was confirmed by patients.
- There were arrangements to provide food and drink to patients not on medical wards. There was hot and cold food and fruit available in the discharge lounge for patients waiting for discharge from hospital. On the Eden unit, the senior nurse told us that patients receiving treatment during lunch time were offered sandwiches.
- In April 2015, Healthwatch (Windsor, Ascot and Maidenhead) undertook a review of patient experiences of meal times at the hospital. Results showed that 96% of the patients reported that they were aware of the menu choices with nearly 80% reporting that the food was served at the right temperature and of sufficient quality. 93% of patients reported that they had enough to drink throughout the day.

**Patient outcomes**

- The Summary Hospital-level Mortality Indicator (SHMI) provided details of patient mortality at trust level across the NHS. The SHMI gave an indication of whether the mortality rate of a trust is higher or lower than expected when compared to the national baseline (England). The number of deaths in medical specialities Wexham Park was consistently better than the national average and showed an improvement from 87% in September 2014 to February 2015 where the overall SHMI was 83%.
- The Myocardial Ischaemia National Audit Project MINAP) audit shows that (nSTEMI) patients seen by a cardiologist or member of the team was in line with the national average. Patients admitted to the cardiac unit or ward, and those referred for, or had, an angiography is better than the national average.
- The National Diabetes Inpatient Audit (NaDIA) showed that Wexham Park Hospital performed worse than the England average in 13 of the 21 measures and better in a further seven measures. The areas that the audit flagged as worse than the England average were the number of patients visited by a specialist team, management errors, insulin errors, foot risk assessments, food timing, choice and suitability, staff knowledge over a number of areas and overall

satisfaction. In response to this audit, the staff knowledge domain has been addressed with the provision of new e-learning modules. The trust has also reviewed the implementation of 'hypo' boxes across the hospital.

- In the Sentinal Stroke National Audit programme (SSNAP) Wexham Park Hospital scored level D across each quarterly audit between January 2014 and June 2015. However, it is worth noting that although the trust collects the data by site to monitor its services; Wexham Hospital has an acute stroke unit but is not commissioned to provide hyper-acute care which many of the SSNAP metrics assess and this would adversely affect the rating awarded. However, it should also be noted that the majority of trusts achieve a D score in the national audit.
- The standardised relative risk of readmission for elective admissions was worse than the England average and for non-elective admissions was in line with national averages. It is worth noting that elective admissions account for only 3% of the directorate's activity. The best performing specialities were cardiology and respiratory medicine with standardised scores of 96 and 89 where 100 is the national average.
- The Joint Advisory Group on GI Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. The hospital had current accreditation for its endoscopy service.
- The hospital participated in an annual neutropenic sepsis audit. In 2014 there were 40 suspected episodes of neutropenic sepsis of which 27 were confirmed. Time to treatment from triage was less than one hour for all but eight cases, with all but two patients treated within two hours. There were no deaths reported due to neutropenic sepsis.
- However, staff we spoke with raised concerns that the consistency and standards of care delivered to patients with neutropenic sepsis (chemotherapy related complication) on the general wards were not in line with hospital policy. Issues included treatment times not adhered to and bloods not monitored daily. We saw evidence that these concerns were raised in the minutes of the April and September 2015 Cancer Unit Steering Group meetings. To address these concerns the MacMillan Cancer Care Facilitators set up 10 minute drop in sessions on Wards 2, 4, 5, 6 and the Acute Medical Assessment unit to set out the key points in the management of neutropenic patients. In addition, senior nurses discussed any incidents at weekly catch up meetings.
- The lung cancer service received 614 new referrals in 2014 (a 15% increase on 2013) with 222 new cases of lung cancer diagnosed. The National Lung cancer database (2014) data showed that 74% of patients diagnosed with small cell lung cancer received chemotherapy and 16% of patients with non-small cell lung cancer received surgical resection, both of these are better than the national average.
- The respiratory department was in line with national averages in relation to its organisational score in the 2014 National Royal College of Physicians /British Thoracic Society (RCP/BTS) audit. They scored better than the England average for provisional treatment for respiratory failure.

**Competent staff**

- We saw there were induction programmes in place for new staff. Two HCAs we spoke with described their one week induction that included mandatory training. All nursing staff had preceptorship for the week following their induction.
- Medical staff were provided with a formal departmental induction booklet which outlined organisational issues, training arrangements, leave protocols and who they contacted for support. A senior clinical supervisor was allocated to each new medical member of staff. Foundation doctors had their own consultant appointed to oversee their progress within the directorate.
- There was a preceptorship programme in place for newly qualified nurses and new health care assistants (HCA). An HCA described preceptorship programme they had undergone and described it as useful.
- Staff said there were development opportunities and programmes in place, there were "career clinics" held to support staff in their learning and development. On Ward 9, staff told us about the career clinics and that

there was an allocated staff member promoting band 3 and 4 posts. A new care certificate programme had been designed and all new HCAs would be enrolled on this program.

- Dementia training was available and staff told us they had attended level one training. An external specialist dementia nurse also provided training within the hospital.
- Some staff told us they found it difficult to get time to attend training and sometimes did the training in their own time. They felt this was related to the staffing levels on the wards.
- We found that when there were gaps in staff competence and knowledge identified action was taken. In May 2015, oncology patients were no longer cared for on a specialist ward but throughout the hospital in generalist wards with the aim of medical specialists managing their patients with advice from oncologists. Prior to this move, generalist staff received no training or education to support the move of oncology patients. Concerns were raised that shortfalls in care existed for this patient group in the management of their complex needs. To address this, the trust had recently introduced training sessions on the generalist wards to upskill the staff on the needs of cancer patients. We were unable to review the future training programme.
- There were arrangements to improve staff skills in relation to cancer care. Three MacMillan funded cancer care facilitators (CCF) were in post and reported to the lead cancer nurse. Their role was to work clinically and enhance cancer care through facilitation, role modelling, change management and clinical leadership. We were able to review teaching and education achievements of the CCF's which included: a weekly cancer rolling training programme for generalist staff on Wards 1, 9, and 11; completing basic competencies for band 5 RN's on Eden Ward; the scoping of cancer needs on Eden Ward.
- Staff administering chemotherapy were competent to do so. The Eden Day unit's senior nurse told us that chemotherapy nurses had completed their N59 certificate in care of patients having cytotoxic chemotherapy. The CCF's had recently implemented the national chemotherapy standards and competencies around the delivery of chemotherapy. These, we were told, will be carried out annually. We reviewed the data submitted by the trust and found that on Eden Ward and Day unit, 11 RN's had completed their annual competency with two RN's due to get their competencies signed off. We saw a completed competency record.
- We were told that staff agreed to a learning contract when provided with specific training for their role. Staff agreed to stay for one year following a funded course.
- Annual appraisals were in place for staff. We saw examples of completed appraisal documentation with input from the manager and the member of staff being appraised. Learning and development needs were identified at appraisal. Staff appraisals were monitored centrally by the human resources department.
- We were provided with evidence of an example where poor practice had been identified and was being managed using appropriate Human Resources policies

**Multidisciplinary working**

- We found that patients had access to the full range of medical, nursing and therapy services expected.
- We attended the weekly multidisciplinary meeting for stroke patients. This was a consultant led well-structured and well attended meeting. A clear summary of each patient was provided followed by a systematic review of the key issues where the multidisciplinary input was valued.
- Every Monday there was a multidisciplinary discharge planning meeting on Eden Ward. We were told that there were daily multidisciplinary meetings (MDT) on all other wards.
- We found good working relationships between the medical in-reach consultants and the emergency department.
- We attended a whole hospital handover meeting at 9pm attended by doctors, senior nurses and managers. This was led by a registrar with the consultant present. There was a clear structure that all attendees followed. Individual patients were discussed where there were specific concerns. Other

specialties such as surgery and intensive care attended. Individual ward handovers followed. This was an effective and safety focused handover that enabled team building and staff empowerment. Development of the process was on going.

**Seven-day services**

- We found that the medical directorate was actively working toward the provision of seven day service. The vision of the Directorate was to move closer to seven day service delivery which currently existed in Cardiology and Acute medicine. Gastroenterology provided an Endoscopy service seven days a week at the hospital.
- The current medical model was designed to deliver five day consultant presence across all specialties ensuring continuity of care is paramount. Acute medicine provided over 12 hours consultant-led service for emergency referrals seven days a week, with at least two consultants present out of hours.
- The Cardiology service provided a Primary Percutaneous coronary intervention (PPCI) service five days a week and was awaiting agreement to extend this to seven days a week, the service had two cardiac catheterisation laboratories and had expanded its non-interventional services.
- Respiratory services provided an integrated model of care in partnership with Berkshire Health Foundation Trust.
- There was a consultant presence on the acute medical take until 9.30 pm. This meant that patients could be seen by a consultant within a maximum of 14 hours if admitted after this time. The morning post-take ward round function was shared between two consultants in order to achieve this.
- There was a five day Ambulatory care service seeing medicine and surgical patients, GPs could access the unit directly.
- The liaison hospital palliative care service was available to support patients with symptom management and other concerns seven days a week.
- A twenty four hour telephone service was provided by the palliative medicine consultants (shared rota with the Thames Valley Hospice). They were contactable via the hospital switchboard.
- In response to a national audit the respiratory department negotiated a seven day working pattern for respiratory specialist nurses in order to improve the accessibility of a specialist nurse for patients admitted with acute exacerbation of (COPD).
- Out of hours the consultant haematologists ran an on call system with advice available at all times via the hospital switchboard.
- The medicine physiotherapy team ran a Monday to Friday service which included 11 qualified physiotherapists and five physiotherapy assistants. Weekend cover was provided by the ITU team who saw respiratory patients as required.
- The medicine occupational therapy (OT) team ran a seven day service. Between Monday and Friday this included 14 qualified staff and seven occupational therapy assistants. Weekends were covered by two qualified OT's and one OT assistant.
- Dedicated pharmacy teams supported clinicians, attended ward rounds, and offered patient advice seven days a week.

**Access to information**

- Staff told us that their main source of information on trust policies and clinical guidelines was on the trust intranet. We were shown examples on-line such as the trust consent policy and resuscitation policy.
- Wexham Park Hospital had an electronic system for recording the results of patient investigations. Clinicians could view the results from various locations and by remote access. The clinicians we spoke with told us the system worked well and gave them real time updates and information wherever they were.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Training in the Mental Capacity Act formed part of the mandatory training programme.

# Medical care (including older people's care)

- We saw evidence of multidisciplinary best interest discussions, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and family discussions in patient records we reviewed.
- We found a good understanding of powers of attorney and family involvement demonstrated at the stroke multidisciplinary meeting.
- Staff we spoke with on Ward 18 demonstrated good knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We were told there were six patients with a DoLS authorisation in place and saw that these had been fully completed. Staff found that there were delays in receiving approval but the staff were completing their part of the process in a timely manner. On Ward 17 we saw the records of a patient where an urgent DoLS form had been completed and sent to the local authority for approval.
- We saw three examples of consent forms for patients who lacked capacity to consent for themselves. These were filled in as required; however the form did not contain prompts for consideration of specific decision points or legally important aspects. None of the forms were completed by consultants.
- On visiting a ward we observed a patient who had returned for aftercare following neurosurgery and saw that a health care assistant (HCA) was providing 1:1 support. To ensure patient safety, the bed rails were used and the patient was wearing mittens. We observed that when physical restraint was used it was proportionate and directed by safety concerns. Staff we spoke with displayed clear insight into the challenges and ethics/legality of restraint.

## Are medical care services caring?

Good

We rated the medical care (including elderly care) at Wexham Park Hospital 'Good' for 'caring' because:

- The hospital had systems in place to allow patients to feedback their experience of care on the medical wards. Feedback from patients and those close to them was positive with regard to the way staff treated people.
- We observed staff treated people with dignity and respect. Patients felt well supported and well cared for as a result. We saw staff were kind and had a caring, compassionate attitude which enabled them to build positive relationships with patients and those close to them.

**Compassionate care**

- We saw that the Friends and Family Test (patient feedback tool) information was displayed in the ward areas. The hospital achieved a response rate of 56%, better than the national average of 36% for the period March 2014 to February 2015. For the period from October 2014 to August 2015 there were high numbers of responses for those that would recommend the service to their families and friends. Individual ward averages for this period ranged from 92 - 96%.
- In August 2015 scores FFT scores for medical wards ranged from 88 - 100% with four wards achieving 100%.
- We saw many examples of compassionate care provided by staff on the various wards that we visited. For example, on the discharge lounge staff checked each individual patient's needs, ensuring that the environment was safe for the varied patients that came through for discharge.
- Typical comments we received from patients included: "Marvellous care, always excellent;" "Fantastic care;" "Always looked after."
- We found examples of caring practice. For example, we observed staff managing an incident where a patient became verbally aggressive with care and calmness. We were provided with an example where a vulnerable adult confided specific concerns to a doctor. This was discussed with the wider team so that appropriate care and support could be provided to the patient.

**Understanding and involvement of patients and those close to them**

# Medical care (including older people's care)

- Patients we spoke with said that staff explained care and treatment plans and that they were provided with good information. We observed nursing staff introducing themselves to patients and relatives. On Ward 3 we saw staff communicating well with patients and their relatives and spending time with them.
- On the stroke unit the ward clerk demonstrated high quality telephone communication with a family.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting patients with their food on the dementia ward.

**Emotional support**

- Medical and nursing staff provided emotional support for patients and we observed occasions when this occurred.

## Are medical care services responsive?

Good

We rated the medical care (including elderly care) at Wexham Park Hospital 'Good' for 'responsive' because:

The needs of local people, commissioners and stakeholders were taken into consideration when planning services. There were established medical pathways of care through the hospital from admission to discharge. Policy and procedures were in place for the safe and timely discharge of patients from hospital.

Patients were supported to access care at the right time, and there were some systems for providing care closer to home.

The directorate understood the different needs of its individual patients and designed and delivered services to meet those needs.

Although some medical patients were treated in other areas of the hospital when beds were not available systems had been put in place to ensure the consistent quality of their care.

Patients were encouraged, and had the information they needed to provide feedback or make a complaint. The directorate reviews and acts on information from complaints. The systems for managing complaints had improved since our last inspection.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

Bed occupancy rates were high and average lengths of stay for the majority of medical patients was longer than the England average.

**Service planning and delivery to meet the needs of local people**

- System resilience groups operated across Care Commissioning Groups to inform acute care planning and whole system escalation response. The medical directorate engaged with these forums. Recent discussions focused on frail elderly care provision and community bed resource, which we saw had informed the trust's evolving frail elderly strategy.
- The hospital screened frail elderly patients at the point of entry to the hospital with a four point screening tool that triggered a multidisciplinary response if potential challenges and risks were identified.
- There were guidelines in place for criteria for patient admission to monitored beds in the acute medical unit (AMU) to ensure that those requiring this level of support could access it.
- There was a five day ambulatory care service seeing medicine and surgical patients which GPs can all access directly. A dedicated anti-coagulation Nurse Specialist/Pharmacist team was able to assess, treat, follow up and discharge patients with suspected deep venous thrombosis (DVT), to agreed protocols. These services enabled patients to be treated "closer to home" and in a timely manner.
- Oncology patients were entitled to free parking during their treatment in recognition of the need to attend multiple appointments at specific times. However, patients told us that getting a parking space could be an issue.

- Eden Ward provided a relatives' room and facilities for them to stay overnight if the patient's condition warranted this.

**Access and flow**

- Emergency admissions accounted for 65% of the directorate's activity, with 33% day cases and 3% elective admissions.
- The average length of stay for emergency admissions was 7.4 days, worse than the England average of 6.8 for 2014. General and respiratory medicine length of stays was longer than average and cardiology at about the average.
- Midnight bed occupancy ranged from 96% to 109% for the period April 2014 to March 2015. This is worse than the directorate's internal target of 95% and the generally accepted standard of 85%.
- For the period April 2014 to March 2015 the directorate achieved 97% of patients treated within 18 weeks of referral for those admitted and 96% for those on a non-admitted pathway. This is better than the government target of 90%. For patients admitted, General and geriatric Medicine achieved rates of 100%.
- No mixed sex breaches had occurred in the Directorate of Medicine in past year.
- Policy and procedures were in place for the safe and timely discharge of patients from Hospital. This policy was developed by the trust to provide guidance to its entire staff who may become involved in supporting the discharge or transfer of care of a patient. It was designed to ensure that patients received the right care in the right place at the right time, and that trust staff understand their role and responsibilities when working with external health and social care partners. The key principles and practices that underpinned this policy were derived from 'Ready to Go' (Department of Health 2010).
- The directorate was involved in projects to improve the timely discharge of patients from hospital. For example, the hospital engaged a local General Practitioner (GP) for 30 hours per week to assist with patient discharge. We saw the electronic real time log that informed the GP of issues with potential to delay a patient's discharge. We were told that the GP worked across all specialties at the hospital and felt that strong relationships had been developed with staff at all levels. The GP worked with external health and care services to enable appropriate and timely discharge for patients.
- Electronic discharge summaries were completed for all patients discharged home or transferred out of the trust, and also in the event of death, self-discharge, or patients absconding from hospital.
- We observed staff from a care home welcomed on to a ward prior to a patient's discharge. This meant that the discharge could be facilitated with clear communication and handover in place for the individual patient.
- Across the directorate there had been 616 bed moves between January 1st and December 31st 2015. Figures varied over the period with January 2015 being the highest number at 73 bed moves and July being the lowest at 24 throughout the month. It is worth noting that January 2015 was a busy period for the Trust. On the wards we visited staff told us that patients over 70 years, those with dementia or were confused would not be moved. However, ward moves increased the risk of spreading infections, disrupted continuity of care and can be distressing for patients.
- We found there were medical outliers on surgical wards during the inspection. For example, there were three on 13 October 2015. We were told that these patients were highlighted at the bed meetings and we saw this happen at the meetings we attended. There was a buddying system in place with medicine consultant teams allocated a buddy ward. Patients were seen by a doctor from the buddy ward and care plans put in place. Wherever possible, and appropriate, the patient would be repatriated to the buddy ward in medicine.

**Meeting people's individual needs**

- Overall, we found there were systems and arrangements in place to ensure that the individual needs of patients and those close to them were met.
- We observed handover at 9pm on the acute medical unit. Individual patients were discussed, including

whether specialist teams were involved in their care and where a new Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision had been made. This ensured continuity of care for patients.

- Patients were assessed on admission for pressure ulcers using the nationally recognised risk assessment tool. Patients found to be at risk were provided with appropriate pressure-relieving mattresses and referred to the tissue viability team who provided specialist care with weekly reviews. Nurses told us there was little delay in getting the mattresses and profiling beds. We saw records that confirmed risk assessments were being undertaken.
- We reviewed a set of medical notes on one of the wards and found a laminated pressure relieving equipment selection protocol chart which was linked to the Waterlow assessment tool. Pressure areas had been identified on the patient and an air mattress had been ordered. We saw that the patient was being nursed on the air mattress during the inspection. However the nursing sister was unable to show audit information regarding how promptly patients received pressure relieving equipment after it had been requested
- Some wards had quiet areas for families and friends to use. On Eden Ward there was a fridge in each room for patients to store their own food
- We saw that there were patient information leaflets on the wards. Examples included dementia, duty of candour, and eating and drinking.
- We saw evidence of the dementia screening tool in place for patients over the age of 75 years however, on a month to month basis, compliance fluctuated. On one of the wards we visited we saw 100% compliance for July with one patient being directly admitted to the ward being screened. However, we saw that compliance had fallen in August and this was thought to be due to the new doctors and staff on annual leave.
- Patients living with dementia were provided with booklet called, "This is me" produced by the Alzheimer's Society. This that provided space for the recording information to assist staff in caring for the patient appropriately and in line with their preferences. However, we saw these were not always fully completed.
- There was a dementia care pathway in place and senior nurse identified as Dementia Specialist Lead with and National Vocational Qualification in dementia care.
- We observed several occasions where staff responded to individual patient needs for those living with dementia. One example was in respect of monitoring and assisting a patient with food; another was in respect of working with an external provider that achieved a better outcome for the patient than that originally proposed.
- Across the directorate a sunflower picture was used at patient bedheads to enable staff to be aware that the patient is living with dementia. The Sunflower Lounge provided an area for patients living with dementia to engage in activities and a variety of music was available together with access to a garden.
- Where it was identified that additional support was required, particularly for those patients living with dementia, then extra nursing support was provided. One to one care for patients was available and provided when required. We saw this during our inspection.
- At the time of our inspection the hospital was updating its directories, including religious and other cultural guides to support clinical staff in communicating with and caring for patients from vulnerable and diverse groups.
- The trust was also working towards a consistent process and procedure to place a single interpretation service across the hospital. These were available from Slough translation services at the time of our inspection.
- We saw examples of assessments in respect of patients' behavioural and psychological needs in the patient records we looked at.
- There was access to the palliative care team and to complementary therapists who provided care such as massage and relaxation to oncology/ haematology patients.

- There was access to multi-faith worship. We were told that the chaplaincy were very responsive when contacted by ward staff.

**Learning from complaints and concerns**

- The directorate had recognised that previously complaints were taking too long to investigate and that those investigations did not always involve the patients, relatives and carers. It was also unclear as to whether complaints led to service improvements. As a result during 2014/2015 a complaints and patient experience manager was appointed in order to improve the process.
- During 2014/15, the directorate had received a total of 195 formal complaints. There was an 11% decrease in complaints received in the second half of that period. The themes identified from these complaints were communication, timeliness of treatment and decision making, staff attitude, continuity of care and discharge decisions.
- In the first quarter of 2015/2016 the directorate had received 33 formal complaints representing a 30% reduction when compared to the same period in the previous year. In the second quarter of 2015/2016 the trust saw a 34% reduction in formal complaints when compared with the same quarter the previous year.
- Service improvement as a result of complaints analysis has included staff training on communication, mental capacity act, end of life care, falls, managing anaphylaxis, as well as improvement in access to food and drink, documentation, awareness of parkingsons medication, escalation routes, access to thrombolysis therapy, access to emergency PEG reinsertion, and anticoagulant follow up. Individual training had also been provided to named clinicians where specific errors were identified.
- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.
- At the last inspection, we found complaints were not dealt with in a timely fashion and a backlog had developed. These had now been dealt with and any new complaints were being managed more effectively.
- The trust had undertaken work to make sure it's Patient Liaison Service (PALS) was more visible. There was an improved uptake of this facility by patients reported.
- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff bulletins such as patient safety, safer medications and infection control, together with the briefings given to junior doctors and the monthly nursing brief. Information about recent complaints was displayed on the wards and any changes in practice highlighted.
- The wards displayed examples of patient comments and concerns on a "You said – we did" board to demonstrate action taken in response. One example on the stroke unit was a concern raised regarding delays responding to call bells. The response under "We did" was that staff had been reminded and the rota adjusted to support known busy times on the ward.

## Are medical care services well-led?

Good

We rated the medical care (including elderly care) at Wexham Park Hospital 'Good' for Well-led because:

- There was a clear, forward looking statement of vision and values for the medical directorate. Staff were aware of the directorate's strategy and were mostly engaged in its progression.
- There had been a hospital wide review of governance processes which had ensured that governance structures and arrangements supported the directorate in the delivery of its strategic objectives, and the provision of safe care.
- We were told of more collaborative culture since the last inspection, and staff reported feeling respected, valued and supported by an effective and visible leadership team.
- There was a pro-active approach to seek a range of feedback from stakeholders, and to act on it.

- Staff were encouraged to innovate and we saw examples of staff innovation that had improved the quality of services for patients.

**Vision and strategy for this service**

- At the last inspection we found there was no clear strategy or vision for the medical services. Following acquisition by Frimley Health NHS Foundation Trust the vision, values and strategy was reviewed and made available for all staff within the trust. We heard from all staff an understanding of the values and what was expected from them. The matrons told us that they found the values helpful. They were clearly displayed in many clinical and non-clinical areas of the hospital, on the web site and on documentation.
- A strategy work list was developed within the medical directorate following workshops held at the hospital in June and July 2015. This demonstrated a clear strategy and vision for the medical specialties which staff had helped formulate and felt engaged with. It included, for example, the implementation of a 24 hour seven days a week primary percutaneous coronary intervention (PPCI) service and planning the demand for medical high dependency unit.
- The trust had a cancer strategy which set out the vision for the service over the next five years. We were told this was developed in consultation with the Thames Valley Clinical Senate. This would move the current service from a two centre provider model to one providing the full range of haem-oncological services with the Frimley Health lead cancer consultant and lead cancer nurse overseeing the implementation of the strategy. The change to a one centre provider was designed to improve the patient experience with the introduction of more chemotherapy and a radiotherapy service for patients.
- We heard in the focus groups and from individual staff of the trust's efforts to improve staffing levels by more proactive recruitment through the use of innovative strategies such as "golden hellos".

**Governance, risk management and quality measurement**

- A trust wide review of audit processes across medicine had taken place in 2015. It was recognised that individual departments were reviewing their own audit processes but that trust wide learning was not being disseminated. A clinical effectiveness and audit committee (CEAC) was established in early 2015, with the first meeting occurring in April 2015. The committee has representatives from all directorates as well as services such as pharmacy, radiology, pathology and IT. The committee meets on alternate months with each department providing an annual summary of their participation in audit with the sharing of lessons learnt.
- There was a system of governance which staff understood and could explain. Clinical governance systems was now embedded at speciality level with structured standard meeting agendas complete with minutes and action logs for governance meetings.
- New central directorates had been established to manage complaints, patient safety and quality assurance. This enabled managers to track and trend themes and identify and emerging trends for early intervention.
- The Family and Friends Test had been expanded to include questions, which gave a baseline on the patient safety culture within the trust.
- Quality dashboards were used as a multidisciplinary tool for performance monitoring across the medical division. Data quality was an issue raised at the previous inspection. This was now monitored through a programme of internal and external reviews. Feedback was then given back to the wards, departments and individuals to enable them to provide better quality data.
- Patient safety and patient experience boards were displayed in public areas on the wards which gave relevant up to date information to patients and visitors.
- Each area maintained its own risk register, which fed into the directorate risk register. We reviewed the risk register and saw that mitigating actions were reviewed and updated regularly. The local risk registers were managed by the ward managers. These fed into the directorate risk assurance framework, which were reviewed and updated monthly. These reported to the Board via the Clinical Governance Committee.

- Senior clinicians and managers told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings that took place on a planned basis throughout the medical division.

**Leadership of service**

- Staff were very positive about the changes over the past year. They told us that they were supported by their line managers and that senior staff members and the teams were both visible and willing to work alongside staff.
- We found that there was improved support for practice development and education. The matrons told us that they were undertaking a leadership programme.
- The matrons told us at their focus group that they were supported to work with the Frimley Park matrons. There were regular meetings across the trust's hospitals that enabled joint learning, policy sharing and development towards joined up pathways and practice. This in turn provided a larger support network within the trust.

**Culture within the service**

- We were told of more collaborative culture since the last inspection, where clinicians felt listened to and where staff felt they were both working together and learning together. Staff described the culture as, "More transparent." We were told that the senior management team were approachable.
- An external clinician described being welcomed as part of the hospital. They also felt part of any future development of the service.
- Another consistent message from staff focus groups and individual staff we spoke with during the inspection was of improved communication in both directions from board to ward.
- Staff in the various clinical areas visited told us of the strong team work in place and their pride in working at Wexham Park.

**Public engagement**

- In January 2014 the trust set up the Patient Experience Tracker (PET). Volunteers invite patients to take part in an anonymous survey on their experience on the ward. The aim was for five patients from each ward to take part each month. The results were fed back to the wards.
- The trust provided their quarter one report for the period April to June 2015 with comparisons against the previous three quarters and some comparisons against the Friends and Family Test (FFT). We saw that the medicine directorate's percentages of patients who would recommend the service were broadly similar to the FFT results for the four quarters reported on.
- Examples of other areas where the medicine directorate scored well included: respect and dignity (improving from just under 90% to 96% over the four quarters), privacy at 97% (new question for Q1 2015) and confidence and trust in doctors (improving from just under 80% to 94% over the four quarters).
- There was one question where the negative response percentage (52%) was higher than the positive (48%) and that was regarding patients being informed of their discharge date. Otherwise the results were positive. The PET results were also presented at individual ward level.
- The Patient Experience Report presented to the trust Quality Committee in September 2015 included the PET results as well as complaints, PALS contacts and examples of changes.
- As part of the Joint Advisory Group (JAG) requirements for accreditation an endoscopy patient survey of the service was undertaken and reported on in May 2015. The objectives were to identify areas of concern or poor patient satisfaction, make recommendations for improvement and to develop an action plan to implement required changes. The findings showed that the service scored above 90% compliance for 19 of the 21 criteria audited with 70% to 89% compliance for two criteria. The report showed that compliance levels decreased for three criteria against the previous year's audit and increased (improved) for 14 criteria. The audit covered areas such as patient information, consent process, explanation of results, privacy, dignity and courtesy of staff. The report included the action plan and examples of individual patient comments

# Medical care (including older people's care)

- The directorate had introduced Senior Nurse ward rounds where a senior nurse reviewed all patients documentation and talks to patient about their care and experience at least weekly.
- The trust linked with the local Healthwatch as well as with the Clinical Commissioning Group lay member overseeing patient and public involvement.

**Staff engagement**

- Staff told us that the Chief Executive and senior management team were very visible.
- A member of cleaning staff told us how proud they felt when the Chief Executive wrote thanking cleaning staff for their hard work and commenting on how clean and shining the floor was in the reception area of the hospital.
- Doctors were involved in trust wide groups such as clinical governance and mortality and morbidity (M&M) meetings.
- The quarterly Family and Friends Test included additional questions regarding values and leadership. The most recent results (April 2014 to September 2015) showed that improvements in staff across the hospital recommending the trust as a place to work up 17% to 57% and in staff recommending the trust as a place to have treatment up 25% to 69%.
- There were feedback forums for junior doctors, junior nurses and healthcare assistants. We heard how the feedback forum had improved conditions for both staff and patients.
- We saw that regular staff meetings were held in all the departments that were minuted. We saw examples of these minutes.

**Innovation, improvement and sustainability**

- The Trust had undertaken a campaign to improve VTE reassessment of VTE scores after 24 hours. This included the launch of a national poster campaign and a redesign of internal processes.
- A six month project in Rheumatology and medical wards looked at initiatives to reduce unnecessary inpatient stays. This used a structured morning board round, computer on wheels, midday MDT meeting to discuss social care packages and an afternoon board meeting. Over the 6 month period of the trial the time taken to declare a patient medically fit for discharge fell from 21 to 15 days. For patients awaiting packages of care the total length of patient stayfell from 46 to 15 days. Elements of this trial have now been implemented as normal practice across the medical wards.
- As part of a drive to improve care noise at night, wards had been supplied with the use of soft opening/ closing bins to reduce noise and had agreed "lights out times" to ensure patients could get adequate rest.

# Surgery

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Outstanding |
| Overall | Good |

## Information about the service

Wexham Park Hospital has orthopaedic and surgical wards, a private ward, a pre-admission unit, a day surgery unit providing 130 surgical beds. There are nine theatre suites.

The hospital currently provides emergency, general trauma and elective surgery. Surgery at Wexham Park Hospital is divided into three teams; the orthopaedics, trauma and plastics team; the general surgery and urology team; and the specialist surgery team.

During our inspection we visited all inpatient areas of the surgical services. We spoke with 44 patients and their relatives. We reviewed 18 sets of patients' records as well as other documentation. We observed care and treatment delivered by staff. CQC held focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 60 members of staff who were working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection. We also reviewed the trust's performance data.

At our last inspection of Wexham Park Hospital we found the surgical services to be inadequate. This was because staff had not always completed the World Health Organisation's (WHO) surgical safety checklist, there were poor staffing levels, and little learning took place from incidents. There were also concerns about the use of the theatre recovery area as an inpatient bedded area, the high number of operations cancelled at short notice, the frequent movement of patients between wards late at night, and the large volume of medical patients being cared for on surgical wards. Staff told us about a culture of bullying in which they were discouraged from raising concerns. Governance arrangements were poor with inadequate systems for monitoring the performance of surgeons.

# Surgery

## Summary of findings

Overall we rated surgical services at Wexham Park Hospital as 'Good'. This was because:

- The majority of issues identified in the previous report had been addressed. The trust had action plans for areas of concern that remained, such as staffing. Staff continuously monitored these plans and took appropriate actions in a timely manner.
- We found that leadership in all areas had improved. Senior staff were visible, available and supportive to all staff. We found that improvements throughout the surgical division meant that patients experienced safe, effective and appropriate care and treatment that met their individual needs and protected their rights. Staff provided care that was compassionate and all patients were treated with respect and dignity. Patients had their individual risks identified, monitored and managed. There were systems to regularly monitor and review the quality of service provided.
- Staff were competent and knowledgeable about their specialties on both the surgical wards and in the theatre units. Mandatory training was generally up to date with further staff training and development available and encouraged.
- Outcomes for patients were good and the surgical departments followed national guidelines. The clinical environments, including the equipment available, were clean and well maintained. Departments undertook frequent audits such as environmental, theatre checklist, infection control and hand hygiene. Clinical governance teams analysed the audits and fed the results back to staff. Where risks were identified there were action plans to resolve or manage them in a timely fashion.
- Incidents and complaints were investigated and handled in line with trust policy. There were systems to feedback to staff any learning from incidents and complaints.
- The trust had recognised that improvements were needed to address the culture within the surgical division and had taken robust action to address the bullying issues. Staff were enthusiastic about the initiatives taken to address the concerns raised at the last inspection and were passionate about the quality of care they delivered.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

- There was a degree of underreporting of incidents. The trust was aware of this issue and had strengthened governance systems and improved training and development in reporting and managing incidents and complaints.
- Although we noted an improvement in medicine management, there were still some practices that did not meet current best practice or comply with national guidelines. Issues included insufficient monitoring of temperatures and security.

# Surgery

## Are surgery services safe?

Good

We rated Surgery at Wexham Park Hospital 'Good' for 'Safe' because:

- There were now robust systems to monitor safety throughout the service. This included clinical aspects such as the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery. Environmental safety was assured through regular monitoring and on-going checking of issues such as infection control, equipment and facilities. The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients. The surgical services used the safety thermometer to monitor and assess the quality of care delivered.
- Identified concerns were closely monitored and actions taken to mitigate the risks to patients. For example, consistently staffing the wards and theatres to the required establishment was an acknowledged concern. Managers had live information as to the current staffing on the wards and in theatres and were able to take immediate action where staffing levels fell below the required levels. Managers discussed staffing levels at regular meetings where the staffing level statistics were updated throughout the day. We found that staffing levels had improved since our last inspection, although there continued to be a number of vacancies across the surgical wards and theatres. The trust's proactive management of the staffing situation meant that understaffing did not impact the care that patients received.
- We found that patients were protected from avoidable harm because there were systems to report, monitor, investigate and take action on any incident that occurred.
- We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights and maintained their safety. The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks.
- We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable patients.
- The general environment was visibly clean and a safe place to care for surgical patients. There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. There was sufficient emergency resuscitation equipment available, appropriately checked and ready for use in suitable locations throughout the surgical services.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

- Although we noted an improvement in medicine management, there were still some practices that did not meet current best practice or comply with national guidelines. Issues included insufficient monitoring of temperatures and security.
- Although the majority of the surgical records and medical notes we reviewed were well completed, the records did not always meet best practice, for example in the recording of venous thrombosis risk assessments and completion of the surgical pathway.

**Incidents.**

- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using STEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both STEIS and NRLS.
- At the last inspection we found the process for undertaking investigations of incidents was slow and there was little learning disseminated to staff.

# Surgery

- Following our last inspection, the trust had taken action to improve incident reporting. New processes and procedures had been implemented. The trust had reviewed all serious incident investigations undertaken since April 2014 and reopened eight for panel review. This demonstrated the new process was fair, open and transparent.
- We found at Wexham Park Hospital all incidents were reported appropriately through the trust's electronic reporting system. There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. Staff we spoke with were aware of the policy and were confident in using the system to report incidents
- The trust now monitored and analysed incident reporting in order to identify areas, which under reported and to target improvement. Incident recording had been improved by staff having computer access to allow them to record incidents electronically. Staff on the wards and in theatre told us that they were much better at reporting now, from the healthcare assistants to the junior doctors and consultants. Because of the lack of previous data this could not be verified.
- There had been one reported never event in the previous 12 months. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented). The never event occurred in theatres and related to orthopaedic surgery. Theatre staff told us of the investigation into the never event. There was an action plan in place to prevent a similar issue happening again.
- 11 Serious Incidents were reported on STEIS between October 2014 and September 2015. When benchmarked nationally, this was in the lower third for numbers of incidents being reported and may relate to the previous under reporting identified by the Trust.
- Learning from incidents across the trust was fed back to staff and had led to changes in practice to ensure patient safety. Staff gave us examples where changes in practice had occurred following learning from incidents. This included a review of the cancer pathway, review of nursing documentation, a re-launch of the sepsis pathway and the introduction of green wristbands for patients at risk of falling. Theatre staff gave us several examples of learning from incidents and changes in practice. For example, different sized syringes were now used following an incident where a drug was administered incorrectly. We saw minutes from staff meetings where feedback and learning from incidents was cascaded to staff both in theatres and on the wards.
- Mandatory training now included patient safety training and reinforced the importance of reporting incidents and a 'No blame but not no responsibility' culture.
- We saw that staff, patients and relatives were supported and informed of the outcome in accordance with the trust's Duty of Candour. The Duty of Candour policy requires healthcare providers to provide patients and their families with information and support when a reportable incident has, or may have, occurred.
- The trust kept appropriate records of incidents that had triggered a Duty of Candour response. The trust's policy included recording communication with the patient and any other relevant information on the electronic reporting system.
- For example between April to June 2015, we noted that 12 responses had been made for the surgical division at Wexham Park Hospital.
- We found that senior clinical staff were more confident in describing the process to us. Whilst other staff did not always understand the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.
- We spoke with consultants and senior managers, who told us about the clinical governance, risk and mortality and morbidity (M&M) meetings, which were held monthly by directorate and were used to discuss any learning from incidents. Minutes of the M&M meetings were available for inspection. These demonstrated learning from recent incidents that had occurred.
- Staff in theatres told us that previously, "if mistakes were made we were shouted at, that is no longer the case". We observed a consultant sharing learning from a serious incident and reinforcing the changes to make sure the incident was not repeated.

**Safety thermometer**

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers,

catheter and urinary tract infections and venous thromboembolism. We found that the NHS Safety Thermometer information was available on all of the surgical wards we inspected.

- We saw evidence that safety thermometer data was being routinely used to improve the quality of care. For example the number of 'Harm Free Days' were clearly displayed in each area. The staff we spoke with were proud of the results in their area. One staff member told us '193 days that's a really positive thing to show patients'.
- We noted that the Patient Safety Thermometer data was discussed at the ward clinical governance meetings.

**Cleanliness, infection control and hygiene**

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet. We found the surgical wards and theatre department to be adhering to national infection control guidance. We saw a very high standard of cleanliness in all the areas that we visited.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA and C. difficile during 2013/2014. Between April to October 2015 were no reported cases of MRSA or C. difficile bacteraemia. There were no particular issues noted with infection in the surgical wards or theatres.
- We noted that the trust participated in mandatory surgical site infection surveillance service that occurred during the inpatient stay, on readmission and post discharge for hip and knee replacements and fractured neck of femur patients.
- There were designated staff with infection control responsibilities. The hospital had a dedicated infection control team, which provided support to staff five days a week.
- We saw that regular infection prevention and control audits took place in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE). We were told that a recent dip in the hand hygiene audit performance had been discussed with the general surgery team and was now showing an improvement. The most recent hand hygiene audits conducted in theatres demonstrated 94% compliance.
- Audits also took place to monitor standards of practice in relation to national infection control guidelines and to improve patient outcome related to surgical site infections. Following the audits actions had taken place such as reviewing the Trust guidelines on antibiotic prophylaxis and raising staff awareness.
- All surgical areas we inspected where patients were seen and treated were visibly clean and tidy. All patients we spoke with told us the hospital was always kept clean and tidy. They told us they noticed the nurses were always washing their hands.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. We found that staff were generally aware of the principles of the prevention and control of infection (IPC). We observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.
- Equipment was marked with a sticker when it had been cleaned and was ready for use. Disinfection wipes were available for cleaning hard surfaces in between patients.
- Decontamination and sterilisation of instruments was managed in a dedicated facility on site that was compliant with the EU Sterile Services Medical Devices Directive. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, wards, clinics and departments.
- At the last inspection we found that the theatre instrument packaging was often damaged and could not be used. This was a regular occurrence and often caused delays and cancelation of operations.
- At this inspection we found that action had been taken to reduce the amount of damaged kit, such as changing the racking in the sterile supplies store. However staff confirmed it remained a problem which impacted on patients with delays in theatre. A project was underway to review the sterile supply
- The trust had a waste management policy, which was monitored through regular environmental audits. We

saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.

- Linen cupboards were clean and tidy with bed linen managed in accordance with best practices. However, we noted on the Day Surgery unit, boxes were stacked on the floor of the dirty linen cupboard, which was also used for storage. Storing boxes and equipment on the floor makes thorough cleaning difficult and can be an infection control risk.
- The cleaning of the hospital was undertaken by an outside contractor. Cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the contracted cleaners and checked by a manager. The ward staff told us that the cleaning staff were part of the ward team and they took pride and responsibility for maintaining the environment.
- Monthly environmental audits took place and results of audits were available for inspection. The issues highlighted from this included some damage to walls, doors and floors. An action plan was in place for a maintenance programme to address these issues.
- We spoke with the pre-admission nursing team who showed us the MRSA screening that took place for elective patients before they were admitted for surgery. The clinical notes we reviewed demonstrated patients were MRSA screened prior to admission if possible and on admission if they did not go through the pre-assessment pathway.
- Infection prevention and control was included in the trust's mandatory training programme. The trust provided training data which confirmed that 84% had attended infection prevention and control training. Those staff we spoke with all confirmed they had completed this training.

**Environment and equipment**

- At the last inspection we found that risks of old equipment and insufficient quantities of equipment had been identified for some time. Equipment was not regularly serviced and there was no planned maintenance programme. Daily checks on the resuscitation equipment were not always carried out. There were sometimes shortages of basic equipment such as linen and pillowcases, aprons, and gloves.
- Since the last inspection, the trust has conducted a review of all the equipment on the wards. Action has been taken to identify and prioritize areas of high risk and to make sure any essential equipment was made available.
- At this inspection we saw there was a wide range of equipment available. The staff we spoke with confirmed they had access to the necessary equipment they required to meet peoples care needs. Although wards held their own equipment there was also an equipment library, which nursing staff could access for equipment such as intravenous infusion pumps.
- We saw there were systems in place to monitor, check and maintain equipment. We saw records of the monthly equipment checks and servicing that took place. This information was shared with the ward managers who monitored the reports. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
- However in the emergency theatre the lights could not be turned off as requested by the surgeon to aid in viewing the electronic equipment during an operation. This was due to a broken button which had been reported several times and not repaired.
- Emergency resuscitation equipment, oxygen and suction equipment was available in each area and had been routinely checked.Theatres had a 'Difficult Airway' trolley shared between four theatres, which were checked daily by the operating department practitioners.
- Although we did not see the relevant training records, staff told us they had received relevant training on how to use equipment and felt confident and competent to use it.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept.

- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- We noted that the theatres were well organised with good signage. Each theatre had its own office co-located to the theatre, which was a good environment for nursing and medical staff to write notes and access computer information. This supported safe patient care and afforded the trainee surgeons' proximal supervision from the consultant surgeon.
- Both Wards 10 and 11 had been recently refurbished and were in good condition. The staff were asked about the level of service provided by the Estates department, they told us "Good but can be slow sometimes". However on urgent issues they were responsive.

**Medicines**

- At the last inspection we found that although medicines were stored and administered appropriately there were issues which did not comply with best practice in medicine management. Although medicine audits took place the results were not acted upon.
- At this inspection we found regular medicines audits took place such as audits of the management of controlled drugs and antibiotic prescribing. Actions were taken where issues were identified such as a change in the antibiotic prescribing policy. Controlled drugs were regularly checked with entries double signed.
- However, we still found clinical areas such as the Day Surgery Unit where the drug refrigerator was not regularly checked for security and correct temperature and the ambient room temperature was not recorded where drugs were stored. Many drugs need to be kept within certain temperatures for them to remain effective.
- We spoke with the chief pharmacist for the trust who told us that issues with the recruitment and retention of microbiologists meant that antibiotic therapy was not always targeted and there were not the resources to assess microbiological data. However, improvements had been made to review the antibiotic prescribing policy, refine the database and share and benchmark information with other trusts.
- We were told since the last inspection all areas of the hospital had been audited and action taken where indicated. For example a lot of the drugs fridges had been replaced. Recent drug audits indicated 80% compliance with the trust's medicine management policies with 75% of wards now having a daily visit from a pharmacist.
- The medicines and safety group reviewed any medicine management incident that was reported on the trust's electronic reporting system. Two incidents were recorded in the past six months of which one related to surgery. Themes and trends were identified and any learning shared through staff bulletins, staff meetings and the medicines and safety group minutes.
- We carried out random medicine checks in some of the ward areas and found all stock drugs to be stored appropriately and in date.
- We reviewed a sample of Medication and Administration (MAR) charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on charts and on their ID band. The MAR charts we reviewed demonstrated that prescribing was in line with national guidance and that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance with a sticker confirming a completed VTE assessments and that prophylaxis had been prescribed and administered.

**Records**

- At the last inspection, we found that the World Health Organization (WHO) Surgical Safety checklist was not always completed and although the trust had identified this through several audits, little action had been taken. The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through the anaesthetic and operating room to recovery and discharge from the theatre.
- Since the last inspection the trust had re-enforced the importance of compliance with the WHO checklist with consultants, anaesthetists and surgeons. All consultants were informed that those who could not provide the necessary assurance of compliance would not be permitted to operate at the hospital. Compliance with the checklist was now incorporated into the medical staff induction and local induction for all theatre staff. We were told that regular and routine compliance was monitored through audits, peer review and mock inspections.

# Surgery

- At this inspection we found that considerable progress had been made in ensuring staff always complied with the requirement to complete the WHO checklist.
- We observed clear and precise demonstrations of the WHO checklist for each of the elective and emergency surgical procedures undertaken. This was demonstrated to a high standard in the urology theatre. Evidence of staff completing WHO checklist documentation were seen in all patient notes that we reviewed. We noted that compliance with the checklist was closely monitored at every surgical intervention and audits of compliance took place on a routine and regular basis. The audits confirmed there were now very few incidents where the checklist had not been fully completed and each incident was followed up and discussed with the theatre staff. A recent external audit of the WHO checklist demonstrated 99% compliance.
- The senior clinicians we spoke with told us that the strict adherence to the WHO checklist had meant fewer mistakes were being made.
- We saw theatre staff record that they followed the five steps to safer surgery, which included team brief, sign in, time out, sign out and de-brief.
- We looked at samples of medical and nursing records on the surgical wards and in theatre. The hospital used a mainly paper based system of recording care, treatment and surgical interventions. In general, both nursing and medical records were accurate, fit for purpose, stored securely and completed to a good standard.
- Surgical patients followed standardised pathways, which was personalised through individual risk assessments and notes made in the care plans.
- The surgical care pathways included pre-operative assessment such as previous medical and surgical history, allergies together with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable for day surgery were admitted as such.
- Patient notes contained evaluation and progress updates, as well as information in respect to discharge planning. Discharge letters and requests for diagnostic procedures were undertaken via an electronic database.
- The sample of nursing care plans we reviewed usually contained relevant information, which was updated with completed risk assessments in place. However we noted that on Ward 11 a number of care records did not record the reason why the patient had been admitted. Although the information was on handover sheets and in the medical records the relevant information was not quickly available and obvious to staff not familiar with the patient.
- On the surgical Pre-assessment Unit staff told us about the electronic referral cards, which allowed more time to plan and prepare for patients coming in. Staff told us "It's so much better – no surprises!" We were told that these were now used for all surgical referrals apart from orthopaedic, which was due to go live next month. They told us that lack of information on the referral forms was frustrating and sometimes led to delays. Although there had been action taken to improve communication with the clinicians any improvement was happening very slowly.
- The care records included multidisciplinary input where required, for example, entries made by dieticians, physiotherapy and occupational therapists with referral to specialist advice, such as the dietician and tissue viability nurses.
- In theatre we found that there remained a potential for the loss of theatre data due to the IT systems in place. The trust was aware of this; it was included on the local risk register and interim arrangements were in place to ensure the accuracy of data.
- Senior clinicians told us that there was an issue with IT across the hospital sites with different systems not communicating. The trust was aware this was a risk and required improvement.

**Safeguarding**

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- Elective patients' social vulnerability was assessed when they attended the pre-admission clinic. Staff in the pre-admission clinic told us they liaised with social services when vulnerable patients were admitted into hospital. Information to support the patient in hospital and their discharge home was shared with the ward staff

responsible for discharge planning. They gave a recent example where they had liaised with the district nurse, GP and social services to make sure the patient would be safe on discharge.

- On the orthopaedic ward staff told us how the safeguarding leads monitor trends and take action where appropriate. They gave an example where a number of patients had been admitted from the same care home. Action was taken to alert social services. However staff told us that they rarely got feedback about the outcome of any alert they had raised. They felt this would be useful and make the process more meaningful.
- During our inspection, we identified a patient identified as a vulnerable person, who had not been referred to the local authority safeguarding team. The patient had been admitted as an emergency and neither the ambulance personnel, emergency department staff nor ward staff had raised an alert. Following our inspection a liaison meeting had been arranged between the trust and the ambulance provider to review the process and identify any learning.
- We also noted that safeguarding referrals were not always documented in the patients' notes. For example, a set of medical notes on Ward 1 identified clear safeguarding concerns. The sister in charge confirmed that a safeguarding referral had been made but this was not reflected in the patients' medical, nursing or handover care records.
- Safeguarding training was included in the trust's mandatory training programme.
- We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The trust informed us that attendance at safeguarding training had significantly improved with 91% of staff at Wexham Hospital having completed safeguarding training.
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training. They told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed. They were aware of the safeguarding policy and how to access it.

**Mandatory training**

- At the last inspection, staff told us they undertook mandatory training in their own time and expressed concern about nurses' competency assessments. Junior doctors had told us they did not feel supported in their professional development and had not received an adequate induction into their role at the hospital.
- At this inspection, staff told us the trust provided good training and development opportunities. Mandatory training was monitored and all staff expected to attend on an annual basis.
- Staff in the Pre-assessment Unit told us that there was less 'e-learning' since joining with Frimley Heath NHS Trust and the quality of training had improved. They told us they now received relevant training specific to their role.
- We looked at the staff mandatory training records and identified there was a good uptake of training for the surgical wards and theatres.
- We spoke with consultants and doctors of all grades. They told us that mandatory training, such as safeguarding and infection control, was available. Junior doctors now told us that the induction had improved and showed us the induction literature they were given when starting at the hospital.
- The hospital tried to use the same agency staff that were familiar with the trust. We saw the new orientation and induction sheets available to support new temporary staff to the trust.

**Assessing and responding to patient risk**

- The trust identified that improvements in the management of deteriorating patients was a priority. A lead nurse for the management of deteriorating patients had recently been appointed and a work stream was in place to drive improvement across the trust. Actions included ensuring the availability of the resuscitation team, training for newly qualified staff and a review of early warning systems used across the NHS.
- The trust currently used a modified early warning score (EDOD). This scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- We saw examples of staff on the surgical wards using the EDOD system to identify deteriorating patients and ensure that they were seen quickly by a doctor. The care

pathways we reviewed demonstrated that the early warning monitoring system was being used appropriately and detailed the actions taken by staff when the patient's condition required escalation.

- Nursing staff told us that medical support was readily available when required as the surgical team and consultants attended to patients quickly when required.
- Recognised tools were used for assessing and responding to patients risk such as the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots.
- Risk assessments were undertaken where indicated for example moving and handling, skin integrity, nutritional needs, use of bed rails and Venous Thromboembolism (VTE). This information was then used to manage patient care.
- We observed documentary evidence in ward areas that demonstrated good clinical risk management in relation to pressure area care delivery. Patients had risk assessments in place and where a risk was identified appropriate action was taken. For example the patient's position was regularly changed and they had an appropriate pressure relieving equipment in place with specialist nurse input where required.
- We saw day surgery patients had anti-embolism stockings in place where there use was indicated. We also found patients were usually having their risk of developing a venous thromboembolism (VTE) assessed.
- However on Ward 1 (orthopaedic ward) we reviewed 10 sets of medical notes and found that five had poorly completed venous thromboembolism risk assessments. These are undertaken to assess an individual patient's risk of sustaining a blood clot whilst in hospital. This is a particular risk for patients who may have difficulty in moving such as on an orthopaedic ward.
- Nurses on the wards carried out a bedside handover of care at each shift change with a communication book being used in theatres. At shift change, a formal handover of care took place to ensure patients were appropriately cared for. Medical handover between specialities took place through formal referral and agreement.

**Nursing staffing**

- At the last inspection, we found there were regular staff shortages on the surgical wards and in theatre recovery, which affected the care and treatment patients received.
- At this inspection we found staffing had improved although there were still a number of staff vacancies.
- Providing safe staffing was an acknowledged risk for the hospital and there were appropriate action plans in place to monitor and address the risk on a daily basis.
- The hospital had set staffing levels for the wards and compliance with this was monitored at the bed meetings held three times a day. There was a policy to be used when a ward was understaffed and managers monitored staffing levels to ensure that clinical areas were appropriately staffed. This enabled staff to be proactive in dealing with sudden changes in patient acuity or unexpected staffing pressures.
- We saw that monthly compliance with staffing levels was monitored and reported to the Board. We noted that from June 2015 most surgical wards and theatres reported above 100% compliance with the set staffing levels. The only exception was the Day Surgical Unit which reported 82% compliance for June 2015. The hospital's target was for 95% compliance at night and 85% compliance during the day.
- Managers told us that agency and bank nurses were used to cover vacant shifts, and there were now very few shifts where there was insufficient staff on duty.
- The nurse to patient ratios were monitored and the trust supplied data which demonstrated that the surgical wards were usually staffed at 1:6 during the day and 1:8 at night.
- We reviewed staffing rotas and spoke with staff about safe staffing levels and patient acuity. We found there was usually appropriate staff numbers and skill mix in the clinical areas. Staff told us that understaffing would be reported on the trust's electronic incident reporting system. We did not see any recent staffing related incidents recorded.
- Staff on Christiansen Ward told us they were fully staffed now, any agency staff were 'regulars' who knew the ward and were involved in competency assessments, training and appraisals.

- Agency staff usage was monitored on a monthly basis. For example we saw that in June 2015, 24 hours of agency usage was reported on Ward 10, 55 hours on Ward 1, 65 hours on Christiansen Ward, 77 hours on Ward 11 and 79 hours in theatres.
- Theatres used The Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre. This was monitored daily and displayed on the staffing allocations board.
- Staff in the surgical pre-assessment clinic told us how the staffing rota was a live document updated each morning and used by senior managers to assess if there were any staffing issues. They told us they felt there was now usually enough staff to safely care for patients in the unit.
- Managers told us there was a problem recruiting in the area due to the hospital's close proximity to London and the poor previous inspection report. However managers told us that a number of appointments had recently been made and student nurses were now asking to return to the hospital once they had completed their training.
- The trust was taking positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies. We were told actions the trust had taken to address the nursing shortages such as employing administrative staff to free nurses to concentrate on caring for patients, holding regular recruitment open days and revising the benefits package to attract new staff to the trust. A recruitment and retention group met monthly with managers involved in developing local plans such as career clinics.
- Staff in theatres told us how the appointment of two administrative staff in the store room had released clinical staff to frontline patient care instead of dealing with stock and procurement.
- Specialist nurses were available to support patients and act as a resource for staff. These included specialists in tissue viability and diabetes.
- We spoke with agency staff who told us they enjoyed coming to work at Wexham Park Hospital as the staff were friendly and they worked well as a team.
- Staff in the Paragon Suite (private patient unit) were employed by the trust and worked within NHS terms and conditions of employment. We were told that when there were staffing issues in the main NHS hospital, Paragon Suite staff were taken to work in those areas. The last time this happened was one month before the inspection. However they told us they worked with a ratio of 1:6 staffing including the nurse in charge. They told us that this was sufficient to safely nurse the acuity of patients in the unit. The unit currently had several nursing vacancies which were covered by agency staff.

**Medical staffing**

- Medical staff skill mix for the surgical directorate across the locations was similar to the England average with consultants at 40%, slightly higher levels of middle grade doctors, at 19%, against England average of 11%. Middle grade doctors have at least three years' experience as senior house officer or higher grade within their chosen speciality. Registrars made up 29% of the medical workforce, against an England average of 37%. Junior doctors in foundation years one or two contributed 12% of the medical workforce, the same as the England average.
- We were told there was consultant cover every day including weekends. There were on-call arrangements for out of hours, including ad-hoc cover on bank holidays. The emergency theatre had adequate on call cover with two anaesthetists available.
- The junior doctors we spoke with during the inspection told us they felt there was enough doctors to meet peoples care needs.
- Medical staffing rotas were set and agreed with the lead clinician and monitored with the manpower co-ordinator and Associate Director. Medical recruitment was managed by the manpower co-ordinator working with postgraduate training staff.
- The Paragon Suite (Private patient unit) had a doctor dedicated to the unit. The doctor was supplied by a medical agency. The trust had a medical advisory committee (MAC) for the private patient units across the trust who met regularly to discuss practicing privileges and clinical governance issues. Consultants could only admit to the private patient unit if they had been granted practicing privileges by the MAC.

**Major incident awareness and training**

- The trust had a major incident policy which was under review at the time of our inspection.

# Surgery

- Although Wexham Hospital was not the nearest hospital to high risk locations such as Heathrow Airport and the M25 motorway, any major incident there would have an impact on the day to day activities of the service.
- Staff told us that they did not take part in major incident training with other emergency services or health and social care providers. Although within the trust emergency training took place at induction and at regular intervals.
- Staff were made aware of the trust's Major Incident Plan through electronic and paper means. The current policy was available on the trust's intranet.
- The trust had business continuity plans in place for Wexham Hospital. We were told of an incident that occurred earlier in the year where there was a loss of water supply and remedial actions were taken to ensure patients remained hydrated and kept safe until services were resumed.
- There was now an escalation policy in place to ensure a standardised approach when diverting patients to other areas of the hospital when pressures on beds demanded.

## Are surgery services effective?

Good

Surgical services at Wexham Hospital were rated as good in terms of delivering effective care.We rated Surgery at Wexham Park Hospital 'Good' for 'Effective' because:

- We found surgical care was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met national quality indicators. Patient surgical outcomes were monitored and reviewed through formal national and local audits.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this review.
- Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Special medical or cultural diets could be catered for.

However:

- We found that the hospital was not yet offering a full seven-day service. Constraints with capacity and staffing had yet to be addressed. There was limited availability of other support services such as therapies over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

**Evidence-based care and treatment**

- The trust identified that not all policies and procedures at Wexham Park Hospital were in date or reflected current best practice. An action plan was in place to prioritise the policies to be updated and the resources required to undertake this. In the meantime to safeguard patients' policies and local guidelines were being reviewed by the chiefs of service.
- Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff. Staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- The anaesthetics department at Wexham Hospital was preparing for accreditation with the Royal College of Anaesthetists. As part of this process, all of the policies, procedures and guidelines had been reviewed and the trusts compliance with all relevant NICE guidelines assessed. Two guidelines were found to require action in order to be fully compliant. Actions had taken place to reduce risks such as additional training for staff and providing updated guidance.
- The trust had a range of clinical governance groups who were responsible for reviewing best practice guidelines and changes to legislation. Audits took place against

national guidelines with changes to practice shared where appropriate. Each surgical speciality planned their audit activities which were led by a named clinician for that speciality.

- We saw from care records reviewed, and in our discussions with staff that they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care, and venous thromboembolism. For example, anti-coagulant therapy was prescribed for patients at risk and anti-embolic stockings were measured and fitted to relevant patients.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations. For example patients attending for pre-admission assessments, had pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines.
- Following surgery patients were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient, and escalating this to medical staff following the early warning alert system.
- Within the theatre areas, we observed that staff adhered to the (NICE) guidelines CG74 relating to surgical site infection prevention and staff followed recommended practice.
- National clinical audits were completed, such as the National Hip Fracture Database, and the trust's performance was similar to that of other trusts. Data from the National Joint Registry showed the number of knee and hip surgery revisions performed at this trust was similar to other trusts. Information on patient reported outcome measures (PROMs) were gathered from patients who had groin hernia surgery, hip or knee replacements, or varicose vein surgery. Patients were asked about the effectiveness of their operation and the data showed no evidence of risk.
- Participating hospitals collect data relating to surgical site infections (SSI) for different kinds of surgical procedures over a minimum period of three months. We looked at samples of the SSI data and noted that for knee and hip surgery the trust performed better than other similar trusts for the same period.

**Pain relief**

- Wexham Park Hospital pain management service was nurse led with support from consultant anaesthetists with an interest in pain.
- The Pain Team worked in collaboration with the surgical teams to help manage the patients' experience. They received referrals directly from the surgical teams, physiotherapists or from the patient or relative. They also supported staff and patients with any pain issues through information and education.
- There was a single point of contact. We were told that the pain nurses proactively visited wards looking for patients in pain and supported staff to manage their pain better.
- The Pain Team at Wexham Park Hospital was supported by secondment staff from Frimley Park Hospital as well as a nurse consultant who worked alongside staff. The staff on the surgical wards told us the Pain Team quickly responded when asked.
- The pain nurses worked with the practice development nurses to produce and launch trust wide competencies for Patient Controlled Analgesia and Epidural. The trust provided training in pain management.
- Policies and guidance on pain management had been reviewed and inpatients were audited for their experience of pain.
- We saw that information on pain management was available to staff through the 'Pain Matters' newsletter.
- The 2015 Anaesthetics Clinical Governance report contained detail of pain audits which detailed that during the past year 92% of patients were satisfied with their pain management. None of the respondents experienced severe pain following their surgery. 88% recalled being offered pain relief and 92% told the trust that pain relief was offered in a timely manner.
- Staff at the pre-assessment unit told us how pain relief was discussed with patients before they were admitted. Any issues or problems would be noted and flagged for the wards.
- The hospital used a pain scoring tool to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.

# Surgery

- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief. One patient told us how their pain medication made them feel sick and staff had it changed within an hour, they told us the staff were "amazing". Other patients agreed that staff response was prompt and they were never left in pain or distress.

**Nutrition and hydration**

- All wards used a 'risk assessment trigger tool' as part of the admission process, this detailed tissue viability, falls and nutrition, using questions that asked for a 'yes' or 'no' answer. If any questions answer 'yes' then all other risk assessments must be completed, including a nutrition risk assessment and actions. We saw examples of appropriately completed forms.
- Healthwatch undertook a mealtime experience study in May 2015. There were 10 recommendations made such as consistency in the use of red trays and red lids on water jugs and working practices at mealtimes. Policies and procedures were implemented differently ward by ward, indicating a need for staff training in correct procedures. The trust had shared the report with the catering provider and a joint action plan was in place. Actions included reviewing the catering policies across the trust and the catering supplier appointing a Facilities Matron to address the issues.
- Staff advised us there was a quick response rate from dieticians and speech and language therapists (SALT). A SALT completes the initial swallow assessments on new patients who have swallowing difficulties and then provides feeding instructions to nursing staff.
- We saw an example of the ward menu, which detailed vegetarian options, allergies and so on using a code system. However, it was unclear how useful this was as 'Healthwatch: Wexham Park, Patient Mealtime Experience' (May 2015) stated "It was not clear how much patients understood these or could easily see them as patients told us they were unsure what the codes actually meant". The menu also detailed whether a meal was of soft consistency for patients with swallow difficulties. Pureed options were not available on the menu. Where patients needed a pureed meal, staff notified the Sodexo team who then prepared a pureed version of a dish.
- On Christiansen Unit, they had many urology and elderly patients who were particularly at risk of dehydration. For acutely unwell patients the positive and negative balance of fluid input and output was monitored hourly so any issues could be dealt with throughout the day rather than staff noting a shortfall at the end of the shift with little time to make things right. This was proactive rather than reactive practice and complied with 'Guidance for Regulation 14(4)(a)'.
- Staff confirmed that meal times were protected and that all staff assisted patients with feeding when necessary.
- On leaving surgical wards, patients were given information sheets detailing any dietary requirements they should follow, for example fats/protein.
- We went to a staff focus group where staff told us they had a low opinion of the quality of meals available to patients. One staff member told us they felt unable to provide the care they should due to staffing levels, which particularly affected mealtimes. There were also negative feelings around mealtime support from other disciplines, despite mealtimes being 'protected'.

**Patient outcomes**

- At the last inspection we found that the hospital performed significantly worse than the national average for data quality. We spoke with senior clinicians who told us of the problems that poor data collection had had on the hospital as a whole and for the individual clinicians. One clinician told us about the data provided to a national audit showed the hospital had the second highest mortality rate, which was not true and impacted on their professional credibility. Because of the inconsistent data and uncertain quality, it is not appropriate to compare previous year's performance. However, the data quality has since been improved and now presents an accurate picture of the hospital's activity for future benchmarking.
- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) and CRAB (Copeland's Risk Adjusted Barometer) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.

# Surgery

- The current mortality and morbidity figures indicated that outcomes were good against the national average.
- We were told that there was now a consistent and standardised approach to multidisciplinary meetings and morbidity and mortality meetings trust-wide. The trust told us that attendance was good and learning identified with monthly updates and reports to the Trust's Quality Committee. The trust had considered the results from national reviews such as the review into mortality and morbidity, and action had been taken to implement the findings and recommendations.
- The anaesthetics and general surgical departments were participating in a quality improvement initiative for high risk patients undergoing emergency laparotomy. The most recent data demonstrated areas of good or improving practice.
- The colorectal audit results demonstrated a survival rate higher than the national average. This meant that there were measurable improvements for patients with a diagnosis of cancer.
- We were told that the surgical specialities were participating in 38 clinical trials, which were conducted under strict guidelines and the findings used to improve patient safety and clinical efficiency.
- The trust benchmarked their performance against national comparisons with other NHS Trusts such as the national hip fracture database and the national joint registry. Although audit information was available the problems with data collection over the past year meant that it was uncertain if this presented an accurate picture of the hospital's activity over the past year. However the trust has since addressed these issues for future benchmarking.
- For example in the 2015 hip fracture audit based on 265 cases, the data indicated that Wexham Park Hospital had 4 out of 7 measures which were better than the England average;
- The percentage of orthopaedic patients who had surgery on the day of or after day of admission was 77.8%, better than the England average of 72.1%
- The percentage of hip patients who had a pre-operative assessment by a geriatrician was 93.7%, higher than the England average of 83.5%.
- The percentage of hip patients who developed pressure ulcers was 1.1%; better than the England average of 2.8%.
- The percentage of patients who had a specialist fall assessment was 99.7% and better than the England average of 96.1%.
- The mean total length of stay 23.4 days was longer than the England average of 19 days. However the trust's most recent data indicated that the length of stay was within expected ranges with fractures neck of femur and elective orthopaedic surgery performing well.
- The percentage of patients admitted onto the orthopaedic ward within 4 hours was 10.3%; this was worse than England average of 46.1%
- In the bowel cancer audit, case ascertainment was better than the England average but three measures were found to be worse.
- Theatre utilisation for Wexham Park Hospital was 72% for July 2015
- National Emergency Laparotomy Audit 2014: 16 out of 28 measures were not available for Wexham Park Hospital.
- The standardised relative risk of readmission for Wexham Park Hospital was above the national average for both elective and non-elective surgery.
- The Trust generally scored in line with the England average in the PROMs (Patient Related Outcome Measures).

**Competent staff**

- The trust had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies. New employees undertook both corporate and local induction with additional support and training when a need was identified. Senior staff praised the human resources department who helped the clinical staff with appraisals and validation. A pilot fast track for employment was taking place which was helping to ensure staff went promptly through the recruitment process.

- There were new checklists in place for agency and bank staff. This was monitored through a local auditing tool which gave assurance that agency staff had appropriate induction, training and competencies to undertake their role. The agencies had been audited to check their compliance against NHS employment standards. This provided assurance that agencies ensured their staff met these standards.
- The trust told us that following the acquisition of Wexham Park Hospital by Frimley Health NHS Trust in October 2014, the appraisal process across sites had been reviewed. Between March to August 2015 further training in the appraisal process was provided and a series of workshops held. There was a paper based system of recording appraisals for non-medical staff. The data held on appraisals was monitored and reviewed with monthly reports being sent to managers, six weekly reports sent to the Workforce Committee and quarterly reports sent to the board.
- Based on staff survey results for Wexham Park (2014 – 76%), the trust identified that a higher percentage of appraisals were completed than recorded. The trust planned to implement an electronic system to improve the accuracy of capturing appraisal details which would include information for qualified nurses' revalidation requirements.
- Learning and development needs were identified during the appraisal process. Nurses were supported in their learning and development by their managers and practice development nurses who provided ward based training and individual support.
- We saw that in theatres there were training plans in place for each staff member.
- We spoke with the training leads who told us that big changes had taken place since the hospitals acquisition by Frimley Health. They told us the hospital was now a good learning environment with access to mandatory training and further development.
- The trust had revised the methods of collating training data for Wexham Park Hospital to reduce the likelihood of inaccurate recording. Although electronic recording had been suspended, the trust reported that all statutory training records were up to date and reports had been issued to relevant managers.
- A cross site preceptorship programme for all newly qualified band five nurses had been introduced. A cross site care certificate was being introduced for all new band one to four care staff which started in September 2015.
- Managers were supported through cross site leadership programmes for band seven and eight nurses.
- We were told that education budgets were allocated annually to ensure that staff in all clinical areas had access to further education and study opportunities.
- In house clinical training for foundation knowledge started in June 2015, with a Cancer Care module due to start in September 2015.
- Medical staff were trained and supported through deanery and non deanery schemes.

**Multidisciplinary working**

- Care planning took place at multidisciplinary team meetings where there was involvement from all members of the team including doctors, nurses and allied healthcare professionals. We observed positive and proactive engagement between all members of the multidisciplinary team.
- Senior clinicians told us of the changes and improvements to multidisciplinary team working which had increased effectiveness and improved the patients' journey. They told us there was now a proactive approach between all grades of staff and disciplines. There was better tracking of the patient journey and the whole team recognised the importance of adequate administrative support to do this. They gave examples of better planning and less 'fire fighting'. One consultant told us "I'm able to do a better job for my patients".
- In theatres and the day surgery unit planning meetings took place to discuss future theatre lists. The day surgical unit worked closely with the pre-assessment and waiting list teams to co-ordinate the admission of patients. Theatre staff told us that monthly multidisciplinary meetings took place to discuss any issues in theatre and included suggested improvements, any complaints or incidents.
- The Paragon Suite (Private patient unit) had access to the trust's multidisciplinary teams such as therapies, pharmacists and specialist nurses.

**Seven-day services**

# Surgery

- The trust told us that medical staffing cover had been reviewed and plans were in place to address seven day working. However it was acknowledged that issues related to capacity challenges in the trauma, orthopaedic and plastic surgery theatres and the financial implications of providing additional cover for more seven day services would need to be addressed. The trust was holding discussions with staff regarding extending the working day, Saturday working and all-day Sunday trauma lists. This included methods of addressing the staffing shortage.
- The Orthopaedic Department operated a consultant of the week model. This model was being copied by the Plastics Department from September 2015 which planned to have a consultant present on site during the weekends.
- To meet the demands of the emergency workload across all specialties 10 additional consultants had been recruited to the rotas.
- The Anaesthetic Department had increased coverage with a consultant on site on Saturdays and Sundays till 3pm and an on call service thereafter. Further support for weekend working was provided by the radiologists who were on site from 9am to 5pm on Saturdays and Sundays.
- The dietetics and pharmacy services had extended their hours to give further coverage at weekends. Senior clinicians and managers told us that they were working toward seven day working for the physiotherapy services, as it was recognised that this led to a better patient journey and earlier discharges. Although the staffing of the physiotherapy department had been a problem, this was now improving.
- Staff on the wards told us there had been an improvement in the level of pharmacy support they received over the weekends. They told us this helped with discharge planning and patient flow.
- The Urology & Gastroenterology departments also planned to also provide increased consultant coverage at weekends pending recruitment.
- Staff in the surgical Pre-assessment Unit confirmed that the consultant anaesthetist was available on site Monday to Saturday when the clinics were held.
- Consultant cover was available for the wards and theatres seven days a week. This meant that consultants were on site from 8:00am to 20.00pm and an on call system operated out of hours and at weekends.

**Access to information**

- Wexham Hospital had an electronic system for recording the results of patient investigations. Clinicians could view the results from various locations and by remote access. The clinicians we spoke with told us the system worked and gave them real time updates and information wherever they were.
- Information to GPs was sent electronically although all other nursing and medical records were paper based. Patients were given paper copies of their discharge information.
- Ward staff said they attended ward meetings when able and that urgent information would be communicated at handover, where handover sheets were provided. There were notice boards around the hospitals which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.
- Theatre staff received information at theatre 'briefs' and 'debriefs' as well as at departmental meetings.
- Staff told us that most clinical information and guidance was available on the intranet. They also reported having access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Training on consent and the Mental Capacity Act 2005 was available and staff reported there was no problem with accessing the training.
- We were told that best interest decisions and deprivation of liberty (DoL) decisions were taken where indicated and these were formally documented. There were no patients currently being treated under a DoL order.

# Surgery

- On the orthopaedic ward, staff told us the Discharge Team undertook best interest meetings, which included capacity assessments and dementia screening. These were recorded in the patient's records.
- They told us that over the past year four applications for deprivation of liberty safeguards had been made. They gave an example where a patient had suffered injuries which impaired their capacity to consent. They needed to be deprived of their liberty in their own best interests, to protect them from harm and carry out the medical interventions. The staff we spoke with demonstrated a good understanding of the mental capacity act and deprivation of liberty safeguards.
- Consent was audited and there was a trust wide action plan in place. The results of the local surgical consent audits were shared during educational study days.
- Patients we spoke to told us that they had been given clear information about the benefits and risks of their surgery prior to signing the consent form. They were given the opportunity to ask questions if they were not clear about any aspect of their treatment.
- Consent forms identified all possible risks and complications following the procedure. The consent forms we reviewed were fully completed and contained no abbreviations so that patients could easily understand what had been written.

## Are surgery services caring?

Good

We rated Surgery at Wexham Park Hospital 'Good' for 'Caring' because:

The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. We also received positive feedback from patients who had received care at Wexham Park Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

During our inspection we observed patients being treated in a professional and considerate manner by staff. All the staff we spoke with were enthusiastic about the service they provided and gave examples of 'going the extra mile' to ensure patients received good-quality care that they would want their own families to receive.

Patients reported feeling involved in planning their care and told us they received enough information about their conditions. The hospital had a number of specialist nurses who were able to provide emotional support to patients and make referrals to external services for support if necessary.

### Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw that Friends and Family information was displayed on notice boards around the wards and departments.
- The Friends and Family test scores for surgery at Wexham Hospital were overall in line or above the England average. The majority of patients who used the surgical services at Wexham Hospital recommended the service. For example; the Day Surgical Assessment Unit scored 83%, Ward 10 scored 93%, Ward 11 scored 98%, Christiansen Ward scored 98% and the Day Surgery Unit scored 100% out of over 452 responses.
- We spoke with 44 patients currently receiving care, and some of their relatives, who all told us "the care here is really good" and "the staff are amazing".
- On the Day Surgery Unit staff told us that family could stay for the duration of the patients stay on the ward with no restrictions. Patients we spoke with told us of their experiences. One patient told us "I've had excellent care from start to finish", another told us "the staff are so friendly".
- On the surgical wards, patients told us "It's better than a private hospital here". Other patients mentioned "they [the staff] all seem to work as a team – nothing is too much trouble".
- In the discharge lounge we spoke with a patient who had multiple surgical admissions to Wexham Park Hospital over several years. They told us that the staff attitude had "greatly improved since last August". Another patient told us "of all the hospitals I have ever been a patient in this is the best".
- The only negative comments we received related to the inpatient catering service.

- In the Paragon Suite (the private patient wing) patients agreed that the care and treatment they received was excellent. The only difference being there were no complaints about the quality of the food from patients who were seen and treated in this unit.
- We looked at the comment cards displayed on the ward notice boards. On Christianson Ward, there were 87 thank you letters and cards from past patients displayed. On the Day Surgery Unit we saw 15 thank you letters and cards displayed.
- In theatres we observed staff delivering care with empathy and compassion. We followed a patient's journey from the anaesthetic room to theatre and recovery. At every stage theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious and reassuring them before they were anaesthetised and once they were recovering after surgery.
- During our inspection, we saw staff talking with patients in a respectful and caring manner, taking time to explain options and interventions to patients.
- On some of the surgical wards there was a restriction on children under 12 visiting with permission required from the nurse in charge. Staff explained that young children may be noisy and disruptive when patients required rest immediately following surgery. Also patients immediately following surgery may look and sound frightening to a young child. On Christiansen Ward there was a day room which could be used for patients to see their young children if requested or staff took patients by wheelchair to the hospital restaurant where their families could visit.

**Understanding and involvement of patients and those close to them**

- We spoke with patients at all stages of their surgical journey through the hospital. They told us they felt involved in their care and in decision making about their treatment.
- The patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them. They said risks, benefits and alternatives were explained to them. Patients who consented during an outpatients appointment told us consultants were caring and professional. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- On the Day Surgery Unit patients told us the doctors; consultant, anaesthetist and nurses had all explained everything including their pre and post-operative care. One patient who had been admitted several times in the past told us "I can't fault anything; I would recommend this hospital to anyone".
- The trust told us that many staff in the cancer services had undertaken specialised training in advanced communication and were sharing good practice across the trust.

**Emotional support**

- Wexham Park Hospital had arrangements in place to provide emotional support to patients and their families when needed.
- We saw that clinical staff carried out behavioural assessments and assessments of individual psychological and emotional needs either at the pre-assessment appointment or on admission where possible. These were always completed where patients had needs associated with living with dementia.
- Pre-admission staff told us that when it was identified that patients required extra support this was arranged where possible before admission and discussed with the multidisciplinary team. They told us the benchmark was the kind of care they would want their own family to receive.
- The worries and fears of patients were monitored through patient experience feedback. We saw from the most recent figures that surgical services achieved a green rating of above 90%.
- The patients we spoke with told us they were given adequate emotional support when they needed it. One patient told us they attended an 'Open Day' before they were admitted, which included a tour of the ward. They told us they were impressed and found this was very reassuring. The pre-admission visit helped them to feel less nervous about their procedure.
- Staff confirmed there was access to clinical nurse specialists, such as the enhanced recovery nurse, and stoma care nurses, as well as the colorectal nurse, breast care nurse and the palliative care team who all provided emotional support and practical help where needed.
- In the Surgical Pre-assessment Unit staff told us that the on-site consultants were good at providing emotional support to patients and often spent time listening to patients concerns about their surgery.

# Surgery

- Staff on Christiansen Ward told us they got the opportunity and were encouraged to sit with patients as much as possible. There was a quiet area on this ward where staff could take patients and families to break bad news or discuss concerns.
- There was a chaplaincy and bereavement service available seven days a week. Staff told us they were very responsive especially in relation to patients with palliative care needs.

## Are surgery services responsive?

Good

We rated the surgical services at Wexham Hospital as good for responsiveness, because tWe rated Surgery at Wexham Park Hospital 'Good' for 'Responsiveness' because:

- The needs of local people, commissioners and stakeholders were taken into consideration when planning services. The surgical division had delivered improvements in a variety of performance issues for example; the 18 week referral to treatment times, re-admission rates, mortality data, colorectal audit results, cancer targets and complaints. The cancer targets were being met for the first time in six years. This meant that there were measurable improvements for patients with a diagnosis of cancer.
- There were established surgical pathways of care through the hospital from admission to discharge. There was now an escalation policy with clear admission criteria in order to manage peaks in demand and ensure that the care given to high-priority patients was not compromised. The day surgery wards and theatre recovery were rarely used as escalation beds, reducing cancellations for elective surgery.
- The pressures on beds in the hospital meant that there were times when non-surgical patients were admitted to surgical beds and specialist surgical patients were admitted to general surgical beds. However, the situation had much improved since our last inspection and was closely monitored and audited. Patients were still at risk from being moved during their hospital stay but this now rarely took place during the night and was always monitored and record.
- Complaints were acknowledged, investigated and responded to.

However:

- In the theatre department there was little sharing of information regarding complaints.

**Service planning and delivery to meet the needs of local people**

- The trust had arrangements in place to discuss the planning and delivery of local services with commissioners. A monthly meeting took place where feedback and discussion of current issues took place. There was a wide range of surgical activity, both general and specialised to meet the needs of the local population. This included colorectal, breast surgery and joint replacement.
- Surgical services were configured to provide good access for patients where possible. For example, patients had a choice of surgical outpatients and day case surgery at either Wexham Park or Heatherwood Hospital; Ear, nose and throat, vascular and ophthalmology services were being developed in the community.
- Patients were offered a choice of appointment and treatment times either through 'Choose and book' or through personal contact.
- Performance was monitored daily for emergencies, weekly at executive level and monthly at corporate level. We were told that additional resources were in place for periods of high demand.

**Meeting people's individual needs**

- We heard that the hospital was generally able to meet patients' individual needs. For example there was bariatric equipment available to meet the needs of patients with a high BMI (Body Mass Index).
- We heard of the positive initiatives in place to support patients living with dementia. Dementia Leads were reviewing the care of patients living with dementia across all the trust's sites against the Trust's Dementia Strategy.
- Staff on Christiansen Ward told us about the Sunflower Lounge, which was a dementia friendly recreational area for patients living with dementia which offered a calming 'old fashioned' area for patients to relax.

- There were simple measures in place such as coloured drinking glasses which were easier to see and falls sensors to alert staff when a vulnerable person was moving.
- All patients who were over 75 on admission were screened for dementia. The clinical governance team monitored the results of the screening.
- All patients living with dementia had 'This Is Me' forms completed which included preferences and basic information such as how they took their tea and details of the people closest to them.
- Staff told us they were given extra time to spend with these vulnerable patients and that family and carers were used to support hospital staff to maintain contact and continuity.
- Staff had access to resource folders for patients admitted with special needs such as a learning disability. There was an email 'in-box' for staff to raise any queries, referrals or concerns. In the surgical Pre-assessment Unit staff told us about the resources available to support patients living with a learning disability including a 'passport' which would follow the patient through their surgical journey and alert staff to their individual needs and preferences.

**Access and flow**

- On the Day Surgery Unit, we found that both male and female patients were treated together. Although the staff took action to safeguard patients' privacy and dignity, the layout of the accommodation did not meet the Department of Health mixed sex accommodation guidance (2009).
- All food at Wexham Park was provided by an outside contractor to a prescribed standard. The same contactor also provided the catering contract in the Paragon Suite (Private Patient suite); however they had a dedicated chef who provided a higher quality service. The four patients we spoke with on the private patient unit were all complimentary about the food and drink.
- CQC received 56 comments from NHS England about Wexham Park Hospital, 30 of these concerned food and hydration. Of those 30, only two were positive and one neutral. Some of the comments included: "Diabetic food options were not explained", and "Food was left on table out of reach and patient was given no assistance from staff". The two positive comments were that food was hot, although patients have contradicted this in other comments, and that food had improved over the years. NHS England comments regarding hydration included, "Water cups had not been changed in side rooms for up to a week", and that "Tea rounds were irregular and didn't happen every day".
- During the inspection, we visited six surgical inpatient areas and spoke with 44 patients and one relative. They were generally positive about the quality of food, and whether they had enough to drink and sufficient help from staff. However, some comments from patients included, "The food is disgusting, I won't touch it" and "My wife brings in all my food from home".
- On Ward 10 we were advised by a patient that the "agency nurse couldn't make a cup of coffee," and we observed a patient being given congealed steak and kidney pie.
- In response to feedback regarding nutrition and hydration, Frimley Health NHS Trust had issued a 'You Said, We Did' poster detailing changes in practice in response to complaints.
- Staff told us that translation services were available, although none of the staff we spoke with had accessed them. Staff on Christianson Ward told us the translation service was not very responsive, so they tended to use their own staff. They told us that there was usually a member of staff fluent in the language required, or they worked with the family, unless there were known tensions. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased.
- There was little access to patient information literature readily available on the wards or in clinics. Staff told us that if information leaflets were required they would print them straight off the hospital's website. This ensured that they were given the most up to date version. A patient in the Day Care Unit confirmed they had been given sufficient information about their treatment and care by the surgeon.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.

# Surgery

- The clinicians we spoke with told us that the basic design of the building did not always help with the patients' experience. For example they said the building was large and sprawling and got cold very quickly. They told us that patients sometimes experienced delays because of the distances between the wards and theatres.
- We were told that patient delays from the Day Surgical Unit sometimes occurred due to lack of capacity for patients to receive pre-operative care and treatment. They gave examples of pre-operative enemas being delayed because of lack of toilet facilities. They said that although patient safety or dignity was not compromised this caused delays to the theatre lists.
- Clinicians told us they were especially proud that cancer targets were being met for the first time in six years with cancer waiting times reduced.
- Elective access to specialty surgical services was via a two week rule and urgent clinic slots. Patients were triaged where appropriate. The cancer referral data indicated that 95% of patients were seen within two weeks.
- Emergency surgical services were in place for all specialities, with priority access to theatres via consultant led reviews. There was a dedicated emergency theatre that was always available all day. We found that only seriously ill patients were operated on at night in line with the Royal College of Surgeons Unscheduled Surgery Guidance.
- A formal policy was now in place to provide guidance for staff when cancellations had to be made in order to avoid cancellation on the day of surgery. A monthly report was sent to each speciality to map any trends or themes and take action to reduce cancellations on the day.
- The trust had a target of less that 0.8% of procedures should be cancelled on the day of the procedure measured against total trust elective activity. The data provided indicated that between April and November 2015 three months were over this target for procedures cancelled on the day. Analysis of the cases cancelled in November gave lack of theatre space, lack of equipment, lack of hospital beds and the procedure no longer required as the main reasons operations were cancelled.
- The senior clinicians confirmed that in the past year staff had delivered improvements in a variety of performance issues for example; the 18 week referral to treatment times, re-admission rates, mortality data, colorectal audit results, cancer targets and complaints. This was confirmed in the national data available for inspection.
- The hospital was meeting the national waiting time target of 18 weeks from referral to treatment for patients undergoing planned general surgery, trauma, and orthopaedic surgery. For example to October 2015 92.7% of orthopaedic and trauma patients met the referral times against a target of 92%. General surgery and urology showed an improving picture with the target being met in October 2015. ENT surgery met the target for the majority of the year with an overall rate of 93.1%. Although the Plastic surgery department did not meet the target for October the year to date showed 92.1% compliance.
- At the previous inspection we found that surgical patients experienced delays and short notice cancellations of their pre-operative assessments and operations. Patients experienced multiple bed moves throughout their stay in hospital, sometimes late at night. When beds were not available on the surgical wards patients were cared for in the recovery area of theatres and elective operations were cancelled. Previously discharges were rushed with staff feeling pressured to discharge patients quickly in order to free up beds. As a result, patients were not being given required outpatient appointments, whilst other patients with complex needs were not discharged on time.
- At this inspection, the trust told us of the actions they had taken to address these issues. New guidelines were in place outlining the criteria for moving patients, and audits had taken place to monitor compliance with the bed moves policy. Any patient who was moved after 10pm was reported and any harm related incidents or poor patient experience relating to non-clinical bed moves was monitored and reported at the Quality Committee.
- There was now an escalation policy with clear admissions criteria in order to manage peaks in demand and ensure that care to high priority patients was not compromised. This meant the day surgery wards and theatre recovery were rarely used as escalation beds, reducing cancellations for elective surgery. Plans were

in place for the development of Heatherwood Hospital to provide further flexibility for the management of elective surgery during emergency surgical escalation at Wexham Hospital.

**Learning from complaints and concerns**

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.
- At the last inspection, we found complaints were not dealt with in a timely fashion and a backlog had developed. These had now been dealt with and any new complaints were being managed more effectively. Specialist staff were now managing complaints centrally.
- The Patient Liaison Service (PALS) was more visible and there was improved uptake of this facility by patients.
- We spoke with members of the PALS team who told us that the main complaints raised were about surgical cancellations.
- Since the last inspection, the trust had developed a policy regarding the Duty of Candour. This is a requirement on NHS services to provide support and relevant information to patients and their families when a reportable patient safety incident occurs. The trust explained the new policy and gave examples where patients and their relatives had been fully informed and involved in the investigation and provided with regular updates.
- Complaints were monitored and discussed at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff bulletins such as patient safety, safer medications and infection control, together with the briefings given to junior doctors and the monthly nursing brief. Information about recent complaints was displayed on the wards and any changes in practice highlighted.
- The trust informed us that there had been a significant reduction in overdue complaints and new complaints received.

## Are surgery services well-led?

**Outstanding** ☆

We rated the surgical services at Wexham Hospital as good for well-led. The surgical directorate was well-led because sWe rated Surgery at Wexham Park Hospital as 'Outstanding' for 'Well-Led because:

- The surgical directorate had robustly addressed issues of poor performance and staffing issues. The W.H.O. checking mechanisms, staff appraisals, referral to treatment times and cancer targets had all improved because the surgical directorate was well-led with strategic objectives in place. These objectives were developed in collaboration with staff and in line with a publicised trust vision and value set.
- The trust operated an effective governance structure with robust clinical governance and reporting arrangements in place. Risks were identified and acknowledged and action plans were put into place to address them. Care was evidence based and action plans were constantly reviewed.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about working at Wexham Park Hospital and the majority spoke enthusiastically about what the future held for the hospital. Staff reported the new leadership culture made them feel valued and respected.
- Managers spoke enthusiastically about their ward or department and were proud of the teams they had working with them. The trust actively engaged with the public and staff through meetings, surveys and communications.
- There were systems to ensure patients were heard and listened to. Improved data collection was able to demonstrate that areas of care had improved, for example in the care of cancer patients. We saw the trust encouraged local initiatives to improve patient experience, care and treatment.

**Vision and strategy for this service**

- At the last inspection we found there was no overarching vision or strategy for developing or improving surgical services. Staff at the time were unaware of any unifying vision or any surgical strategy for Wexham Park Hospital.
- Following the acquisition of Wexham Park Hospital by Frimley Health NHS Foundation Trust in 2014, the trust's values, vision and strategic plan was reviewed and revised.
- The trust told us that each surgical speciality now had a service plan for the current year and was in the process of developing and refreshing their three year vision and strategy.
- Progress with the strategic plan was monitored at the directorate review meetings with the executive team.
- The Chief of Service was appointed from Frimley Park Hospital. We spoke with the senior members of the surgical directorate who told us how the trust's values were now embedded throughout the surgical directorate and were monitored through local work and the appraisal system.
- The surgical Chief of Service was supported by senior clinicians from both Frimley Park and Wexham Park Hospitals.
- The staff we spoke with were aware of the trust's vision and could discuss it with us.
- We reviewed the trusts Quality Strategy for the surgical division, 2015/16. This set out the short, medium and longer term plans, with a view to providing a service that met the current and future needs of the local population.
- We observed the trust's vision and values were prominently displayed in hospital corridors, on wards, in literature, on key documents and on the trust's website for patients, visitors and staff to comment and understand.

**Governance, risk management and quality measurement**

- At the last inspection we found that significant risks were identified at divisional level including capacity pressures and concerns about staffing. However, risks at local team level were not always identified or addressed, for example the concerns raised about bed moves and the impact on theatres when using the Day Surgical Ward for escalation beds.
- The trust implemented a new governance and committee structure with Board level quality assurance informed by new quality committees for the Heatherwood and Wexham Hospital sites. For example a new governance and committee structure for cancer services had been established with a Cancer Board that met monthly. Four meetings had been held so far and minutes and actions from the meetings were available. Compliance with the national Cancer Peer Review took place with an internal validation panel for cancer care.
- Clinical governance was now embedded at local level with structured standard agendas complete with minutes and action logs. The local groups reported to the quality committee and to the Board via the Trust's Clinical Governance Committee. Minutes from these meetings were available for inspection and we noted that all risks, incidents and complaints were discussed.
- New central directorates had been established to manage complaints, patient safety and quality assurance.
- A Patient Safety Committee had been established at Wexham Park Hospital and met monthly to share outcomes and take pro-active actions taken to improve safety. Priorities of pressure damage, medication safety, falls, cancer pathways, multidisciplinary teams, radiology and managing deteriorating patients had been established.
- Service level Agreements were in place with other organisations that provided services for Frimley Health NHS Foundation Trust such as Maxillofacial services at Northwick Park Hospital. We were told of the good working relationships with primary care clinicians that had improved care for urology patients and those suffering with back pain.
- Quality dashboards were used as a multidisciplinary tool for performance monitoring across the surgical division. Data quality was an issue raised at the previous inspection. This was now monitored through a programme of internal and external reviews. Any inaccuracies identified were acted upon by the head of information for example the accuracy of the 18 week referral and cancer data produced previously. Feedback was then given back to the wards, departments and individuals to enable them to provide better quality data.
- We saw evidence of the new clinical governance and risk management initiatives. Minutes from all clinical governance and risk meetings were available for inspection and for staff to read. Information boards were

in place on the surgical wards and pre-assessment clinic, which gave information on surgical team responsibilities, supervision, training opportunities, appraisals and team meeting minutes.
- Patient safety and patient experience boards were displayed in public areas on the wards which gave relevant up to date information to patients and visitors. For example on the day surgery unit we noted infection control was running at 100% compliance and there had been 193 harm free days. This meant that it was this long since a patient had had a fall or developed a pressure ulcer.
- The Family and Friends test results were displayed and documented 98% completion rate. Any concerns that had been raised were displayed alongside of the action taken to resolve the issues; for example concerns relating to mealtimes.
- The Family and Friends Test had been expanded to include questions, which gave a baseline on the patient safety culture within the trust.

- Each area maintained its own risk register, which fed into the directorate risk register. We reviewed the risk register and saw that action plans were updated regularly. For example, in the surgical assessment unit environmental issues and the management of electronic records were raised as issues. The risk register detailed the impact of the risk on patients and the actions that had taken place to mitigate the risks.

- The local risk registers were managed by the ward managers. These fed into the directorate risk assurance framework, which were reviewed and updated monthly. These reported to the Board via the Clinical Governance Committee.

- Senior clinicians and managers told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings that took place on a planned basis throughout the surgical division.

- Senior clinicians told us they were proud that some of the processes that worked well at Wexham Hospital were being adopted at the Frimley Park Hospital. They gave examples of the orthopaedic governance process.

**Leadership of service**

- At the last inspection we found that the surgical services were not well led. Senior managers and lead clinicians did not monitor performance against key performance indicators or clinical outcomes. In theatre recovery capacity pressures were not well managed with recovery staff having no managerial support.

- Since the last inspection the new executive team had taken action to ensure they were visible on the wards and in the departments and ensured they engaged with front line staff, listening to feedback and acting promptly on any concerns raised. Senior staff walkabouts were undertaken to engage with staff and obtain direct feedback.

- We spoke with the senior directors and senior clinicians with responsibilities for the surgical divisions. They told us that the Chief Executive was very approachable and they felt better supported. Although there was on-going work to do, they felt there was more structure and access to management. They gave examples of support in improving staffing levels, better complaints handling and clearer strategic direction. One senior clinician told us “It’s as different as night from day – we’re now facilitated to do our job”. They told us that staff were being empowered to improve their services and that good teamwork has helped to drive the changes. One senior clinician told us “No one is bigger than the team” and “Poor behaviour will not be tolerated”

- Staff told us about the leaders and managers in their specific area of work. The staff in theatres were complimentary about the support and leadership within theatres.
- We were told that there was dedicated leadership and management training in place for staff with individual learning needs identified at appraisal. Career clinics were held which were available to all staff to help them with their career progression.

- We were told that the clinical lead for specialist surgery was currently undertaking the NHS leadership programme and the Associate Director of Surgery had undertaken training to MBA level and recent leadership training.
- Senior nurses undertook relevant leadership and management training with all Band eight nurses currently on a 12 month Connect Health leadership programme. All Band seven nurses were undertaking a Leadership and Tools for Change programme.

- In the pre-assessment unit, staff told us how band six nursing staff were encouraged to learn and develop as future leaders through the opportunity of attend governance meetings and spending time with band six nurses from other specialties to improve learning.

**Culture within the service**

- At the last inspection, we found that there was a reluctance amongst senior clinicians to respond to change and adhere to new best practice guidance. We were told of a culture of bullying throughout the surgical services.
- The trust recognised there was a serious issue with bullying and harassment within the surgical division and took urgent and remedial steps to address it. Since the last inspection the trust had established a clear set of values together with the expected standards of behaviour expected from all staff employed by the trust. Direct action had been taken to address the behaviour of individuals who did not demonstrate the professional standards of behaviour expected.
- This positive action demonstrated to staff that whatever their rank, role or seniority, inappropriate behaviour would not be tolerated. A direct outcome of this is was that staff – whatever their role, now felt able to challenge senior staff during the WHO checklists procedure in theatre or on the wards with infection control issues.
- We received much feedback from staff relating to the past and present culture within the service. We heard of individual instances where staff still felt intimidated and belittled by their managers; for example, one member of staff told us how their manager called them "Stupid" in front of other staff and felt they were being denied further training without an explanation. They did not feel able to escalate this because "All the managers are pally with each other" and they could not approach them.
- However in general staff told us that there had been an improvement in the bullying culture as it had been recognised and was being addressed. We were told how issues such as bullying and harassment were now discussed openly at team meetings where appropriate.
- The trust rewarded staff at an annual staff awards ceremony where outstanding contributions to the trust were recognised.

**Public engagement**

- The trust used various means of engaging with patients and their families. These included surveys, such as the 'Friends and Family Test', inpatient surveys, 'Listening into Action' and the 'How Are We Doing?' initiative.
- The results of the surveys, feedback from complaints and the Patient Advice and Liaison Service, as well as patient comments, were reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.
- The trust's website provided quality and performance reports and links other web sites such as consultant performance, NHS Choices and NHS England consultant performance outcomes. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The trust told us that patient feedback surveys were used to drive improvement at ward and multi-disciplinary team meeting level. These discussions were included in the minutes of these meetings. Staff told us that they were proud of the improved patient feedback.
- Patient feedback was used in the 'You said – we did' initiative which we saw displayed on notice boards on the wards.
- The Listening into Action programme enabled staff to be more involved when feeding back to patients.
- The trust told us that new monthly cancer experience surveys were being implemented after the annual national survey in order to make improvements to the service in a more timely way.
- We heard that open days were used to engage with the public. A recent open day was held on the spinal service offered by the hospital. A 'Hip and knee school' took place a Heatherwood Hospital which patients were encouraged to attend. This was an opportunity for patients to discuss with clinicians and therapists practical information and advice relating to their surgery and recovery.
- We heard that clinicians attended Foundation Trust membership events including the recent Annual General Meeting.

**Staff engagement**

- Across the surgical directorate staff told us that "Things were picking up after seven years of decline". They told

us that Wexham Hospital was a good place to work. We heard from members of staff who told us that previously staff did not know who to turn to when things went wrong, but now they were empowered to make changes. Staff were staying longer, with student nurses asking to come back to the hospital to work. The staff teams were now stable making them more effective.

- The senior clinicians we spoke with told us that the hospital really felt like a consultant led service; doctors felt previously that they could have provided a better service and now they were being empowered to do so.
- The quarterly Family and Friends Test included additional questions regarding values and leadership. The most recent results (April 2014 to September 2015) showed improvements in staff recommending the Trust as a place to work up 17% to 57% and in staff recommending the trust as a place to have treatment up 25% to 69%.
- There were feedback forums for junior doctors, junior nurses and healthcare assistants. We heard how the feedback forum for junior doctors resulted in changes to improve conditions for both staff and patients.
- There were staff notice boards available throughout the surgical wards and theatres giving staff information about local and trust wide issues including training, development and team meeting minutes.
- We heard that regular staff meeting were held in all the departments that were minuted.
- Theatre staff told us about the monthly consultant/ departmental meetings; weekly theatre and pain meetings; fortnightly trauma network meetings. We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical. Group emails were frequent and positive in nature.
- Managers told us how proud they were of their staff who "Always went the extra mile" and pushed to do their best.

**Innovation, improvement and sustainability**

- At the last inspection, we found that individuals led improvements and innovations in their own separate areas but good practice was not shared. Although staff wanted to learn, develop and improve their skill they were not given the time, resources of encouragement to do so.
- At this inspection we found that innovation and improvement was now recognised, shared and celebrated.
- We found that staff across the surgical division were passionate, committed to the hospital, and excited about the changes in progress. A clinician in theatre told us "I love working here – it's a unique atmosphere, the working environment is good, really good for training junior staff, younger consultants want to make changes, get on and do things and we are empowered to do it".
- Quality impact assessments (QIA) were undertaken for any major change to a service, this included cost improvement plans. For example the trust had recently re-developed and refurbished two surgical wards and the theatres admission lounge. Staff had been involved in the design of these areas and QIA were undertaken prior to starting the work. The staff working in these areas told us how they had been able to impact on the final design and development.
- We saw that the ward dashboards were used at local level to improve care and where quality audits identified that improvements were needed action was taken immediately to implement this.
- The trust had undertaken a professional nursing engagement event, which celebrated successes in improving quality and safety within clinical teams and rewarded outstanding practice. Innovation and improvement were celebrated through staff award schemes and Committee on Clinical Excellence (CEA) awards for consultant staff. We were told that a number of staff from the surgical teams were recognised in the staff and CEA awards in the past year.
- Wexham Hospital was also signed up to participate in the national safety campaign 'Sign up to Safety' plan and had identified the actions needed to take the programme forward.
- We heard how improvement work in the cancer pathway was currently taking place.
- However we heard from the trust that there was a potential risk to achieving medium term financial

sustainability dues to an underestimation of the financial deficit at time of acquisition. The Quality Committee and Board of Directors Trust were closely monitoring this within its three year Improvement Plan.

# Critical care

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Outstanding |
| Responsive | Good |
| Well-led | Outstanding |
| Overall | Outstanding |

## Information about the service

The Critical Care Unit (CCU) at Wexham Park Hospital has capacity for 12 patients in 10 bed spaces separated by curtains and two private rooms that can be used as isolation rooms. The unit can be flexibly staffed and configured to provide care and treatment for level three intensive care patients and level two high dependency patients and operates as one single intensive therapy unit (ITU). Each bed space can be operated with a 'barrier nursing' model if a patient is highly infectious. The unit offers patients a high degree of privacy.

The CCU cared for 644 patients between April 2014 and March 2015. There is a consultant intensivist on duty seven days a week between 8am and 9pm, and at all other times cover is provided by an anaesthetist based in the nearby surgical and recovery unit. An intensive care outreach consultant is available Monday to Friday from 8am to 6pm.

Patients are admitted to the CCU from other hospital departments. Two dedicated bed spaces in a separate theatres recovery unit are equipped to treat level two and three patients if the CCU is full. These beds are available as part of an escalation policy that enables staff to provide continuous care during periods of high demand.

We spoke with 17 nurses, three consultants, four doctors and six other medical professionals including physiotherapists, a dietician and a microbiologist. We also spoke with two patients and three relatives. We looked at two incident reports, 18 patient records and 50 other items of documentary evidence.

## Summary of findings

Overall we rated the CCU at Wexham Park Hospital as 'outstanding' this was because:

- We found significant areas of good practice through our review of clinical audits, staff training, patient notes, clinical outcomes and other indicators such as an exemplary programme to promote independence and person-centred care. Leadership in the unit was coherent, robust and respected by staff. This leadership contributed to a team that continually challenged existing practice to identify new and improved ways of working. Innovation was very much part of the culture in the unit and staff spoke positively about the development opportunities available to them as a result.
- Clinical practice was benchmarked against national guidance from organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and staff used it to evaluate and improve their practice. For example, an extensive programme of audits was used to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC). They then used the national audit results alongside local studies to inform the planning of staff study days. The CCU team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to

# Critical care

ensure best care for patients. An established critical care outreach team supported patients across the hospital and provided bereavement and emotional support.

- The CCU appeared clean, hygienic and well maintained. Staff demonstrated good infection control practices but there was room for improvement in some areas of housekeeping. Equipment was serviced regularly and staff were competent in its use with regular training updates. We found one area of non-compliance with the trust's medication management policy but there were safeguards in place to ensure that this would not affect patient safety.
- A robust incident reporting system was in place that staff confidently used to investigate incidents and errors. There was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice. These measures contributed to an environment in which safety was prioritised and patients received individualised care.
- We observed numerous instances of significant commitment to personalised care. Staff were competent, passionate and driven, and their efforts included supporting a patient to return home safely to their garden during an extended CCU stay and a programme to promote independence in patient recovery in the middle of their recovery. Staff were active in clinical research and were supported in this by a senior team of nurses and doctors who understood the need for continued innovation in care and treatment. One relative told us, "I am overwhelmed by the attention of all of the people looking after [relative]."
- Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with Royal College of Nursing (RCN) guidance. The use of agency staff was consistently below the maximum acceptable level set by the trust and temporary staff underwent stringent induction and background checks before working on the unit. Without exception staff told us they were supported and valued by the senior team and they felt proud to work in the unit.

- At our last inspection of Wexham Park Hospital, we found critical care services to be good and responsiveness to require improvement. This was because admissions and discharges were often delayed and patients were sometimes transferred out of hours because of a lack of capacity elsewhere in the hospital. At this inspection we found a significant and sustained improvement in these areas, with an acute commitment from the senior team to improve the unit's responsiveness to patient needs that had been highly successful. In areas that we previously found to be good, staff had worked hard to build on their existing practice and explore innovation in patient care and treatment.

# Critical care

## Are critical care services safe?

Good

We rated the CCU at Wexham Park Hospital 'Good' for 'Safe' because:

- There were effective and robust systems and protocols in place to protect patients from harm, and staff contributed positively to an incident-reporting culture that provided opportunities for continual learning.
- Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us in detail about improvements in practice that had occurred as a result.
- Equipment was adequately maintained in line with manufacturer guidance and infection control and cleanliness guidance and policies were followed.
- Staffing in the unit was compliant with ICS guidance. Nurse-to-patient and doctor-to-patient ratios were consistently in line with this guidance. There was a comprehensive programme of training and development in place for nursing staff and junior doctors. Patients received care and treatment from a team that was stable and demonstrated excellent awareness of safeguarding and risk assessment practice.

However, we found some areas that had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised:

- Equipment audits had not included the batteries that formed part of resuscitation trolleys.
- There was a need for improvement in the consistency of cleaning in some areas.
- The medication audit system had not identified a problem with stock rotation, the labelling of some medicine or the correct disposal methods of patient's own medicine.
- We did not find that any patients had been harmed in the areas that required improvement and we saw that processes to address shortcomings had been implemented, including a more robust cleaning policy for high-reach areas.

### Incidents

- Staff used an electronic reporting system to document incidents in the unit. There was a transparent and proactive culture that empowered staff, regardless of their grade or experience, to report incidents in a 'no blame' environment. A practice development nurse (PDN) had arranged 'lunchtime learning' sessions for staff on the electronic system that had included details of specific responsibilities in an investigation.
- The CCU consultant or matron allocated an appropriate incident investigator to each report depending on the expertise needed and they would conduct a root cause analysis. Staff told us that this system worked well and they felt the outcomes of investigations were used primarily to avoid future incidents and to improve good clinical practice. Investigating staff and the matron disseminated the learning from incident investigations to staff through team meetings, study days and individual e-mails and we saw examples of these.
- The CCU reported no Never Events in the previous 12 months. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented.
- There were two serious incidents reported in the unit between January 2014 and September 2015. We looked at the investigation of the serious incident from January 2014 and found that staff had effectively used the NHS England Serious Incident Framework to improve practice. The unit's lead nurse, lead consultant and an anaesthetic consultant had formed a root cause analysis team that had conducted a systematic and robust investigation of the incident. An anaesthetist liaised with the patient's family to ensure they were informed of the investigation's progress and findings.
- From this investigation, senior staff introduced new guidance relating to training and checks for staff in the placement and extubation of tracheotomy tubes. The root cause analysis team had contacted the tracheotomy manufacturer for further advice on training. The new guidelines were detailed and included the use of longer length cleaning swabs for tubes and documented recording of inner tube cleaning. Staff had issued a letter of apology and explanation to the patient, demonstrating compliance with the Duty of Candour.
- We looked at the investigation process of a serious incident that was partially completed. The investigating officer had established the severity of impact on the patient, confirmed that the Duty of Candour had been

adhered to and found no lapse in the care provided to the patient involved. As the investigation had not been completed, we could not see the outcome but the root cause analysis process was thorough and the investigation adhered to the principles of the Serious Incident Framework.

- One nurse told us that they felt well informed of updates relating to safe practices because a health and safety noticeboard was updated regularly. Every member of staff we spoke with could give us examples of recent learning from incidents and told us that communication from senior staff about this was consistently good
- Consultants, doctors and the matron attended monthly Mortality and Morbidity (M&M) meetings that were used to discuss mortality in the CCU. We looked at the minutes of recent M&M meetings and saw that they had led to improved collaborative relationships between specialists. For instance, the review of the death of patient that had been caused in part by a gastrointestinal bleed had led to a more collaborative relationship with the CCU governance lead. The unit had also appointed a mortality lead and contributed to a hospital-wide mortality review. Overall the outcomes of this process contributed to a hospital risk framework that was monitored by the medical director and senior leadership team. The outcomes of M&M meetings were available for staff to review on the learning and development display board.
- Staff included a discussion of critical care outreach team (CCOT) work and decisions during M&M meetings, including the appropriate use of early warning scores (EWS). This helped staff to discuss best practice and learn from mutual experiences.
- The Duty of Candour was embedded into practice in the unit. For instance, staff responsibilities under this policy was displayed prominently on education and communication boards and the electronic reporting system included a prompt for staff to record that they had initiated contact with the patient or relative. Staff we spoke with were able to tell us about their role in the Duty of Candour and we saw it formed part of training sessions in incident management.

**Safety thermometer**

- Staff in the unit contributed to the NHS Safety Thermometer programme. Information was collected on a weekly basis and clear, easy-to-read information was displayed for staff, patients and visitors
- The information showed a high degree of safety in the unit, with no falls or pressure ulcers reported between July 2014 and July 2015. There had been one catheter associated urinary tract infection reported in the same period.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We confirmed this in our review of 17 patient notes and saw that monthly audits of VTE risk were completed to monitor the assessment process during admission. VTE assessments were completed in accordance with NICE Quality Statement 3. Staff were able to discuss safety thermometer risk controls with us confidently and it was clear that they understood the rationale of the programme and how it improved patient safety. VTE risk assessment compliance was audited and in the year to our inspection, compliance was 97%.

**Cleanliness, infection control and hygiene**

- The unit looked clean, well maintained and hygienic.
- Hand sanitizer was readily available in the unit and we observed staff using this regularly and appropriately. We observed staff following the principles of the World Health Organisation's 'five moments for hand hygiene'.
- Hand washing posters were available by each sink in the unit but some were out of date and did not include updated guidance about washing wrists. This meant there was a risk that people using hand-washing facilities in these areas might not be following best practice for hand hygiene.Staff conducted monthly audits of cleanliness and infection control in the unit. In September 2015, hand hygiene compliance was 90% and environment hygiene was also 90%. Housekeeping standards were found to be 94% compliant and IV cannula care was 100% compliant with trust policies. The hospital standard for standards in these areas was 80%. Staff had identified areas for improvement where audits indicated lower rates of compliance, such as more thorough cleaning instructions that included specific areas and equipment.
- Housekeeping staff used 'I'm clean' labels to indicate that an item of equipment had been cleaned and decontaminated. Clinical bed-space equipment was cleaned before being stored in a locked storeroom. We found that labelling of clean equipment was inconsistent and that some equipment had been

cleaned and not labelled. This meant it was not clear to staff which equipment was ready for use and there was a potential infection risk from the use of equipment that could not be verified as clean and decontaminated.

- Disposable curtains were used and had the dates they needed to be changed indicated, All curtains we looked at were within their safe period of use. Disposables trolleys were used and we saw they were clean and within their recommended usage date. This showed us that people were protected from the risks of infection from these items because staff had ensured they were fit for purpose.
- Staff maintained cleaning schedules by each bed space and in the private rooms and housekeeping schedules were maintained on a daily basis, The schedules were displayed in accordance with Department of Health guidelines. However, some areas of the unit that were not immediately visible did not appear to have been cleaned regularly. For instance, we found balls of dust on some high touch areas such as curtain rails and a pendulum that was over a bed. This presented a risk to patients in the bed space from the potential for dust to fall on them or on equipment that was supporting them. This was of particular concern for equipment that had an external air intake, such as ventilators. We talked to the nurse in charge about this and they immediately corrected the problem. We looked again at this area during our return unannounced inspection and found that cleanliness had been maintained.
- We observed that staff in the department were not using a needleless system when preparing injectable medicines. They were injecting directly into a three-way tap without the use of Bionector. Bionector is a closed, needle-free IV access system used to reduce the risks of infection and contamination associated with central venous catheters. This posed a potential infection risk to patients although we did not find that any patients had been harmed as a result of this practice and staff had been adequately trained. We spoke with a chief of service in the hospital who was aware of the issue and told us a more up to date system was being planned.
- Three cases of unit-acquired MRSA had been reported from quarter one 2014 to quarter two 2015 as well as three cases of unit-acquired Clostridium difficile (C.Diff). We saw that each case had been investigated appropriately and that patients had received appropriate care and treatment. Staff had implemented protections to prevent the spread of infection across the unit, including, a decolonisation protocol. This had been audited and compliance was 100%.
- We found a water cooler on the unit that was not plumbed in to a water supply and was not compliant with the Department of Health's Water systems for healthcare premises HTM 04-01 regulation. There was a risk of pseudomonas bacteria building up in the overspill tray and the cooler had not been regularly cleaned to avoid the risk of bacteria building up, presenting an infection risk. We were told that the water cooler was out of use permanently and was scheduled to be removed.

**Environment and equipment**

- Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks, including portable appliance testing (PAT).
- Nursing staff on the unit had maintained resuscitation and emergency intubation equipment with twice daily, documented checks. A lead nurse from the hospital's resuscitation team conducted a routine monthly audit of the equipment, which was repeated after the trolley was used. There were no gaps in the daily checks of the resuscitation equipment.
- Checks of the laryngoscope batteries were not included as part of audits. As a result we found two batteries that had expired in January 2015 and two that had expired in January 2014. This presented a risk that the batteries would not function during emergency use, which could put patients at risk. We spoke with a senior nurse who liaised with the resuscitation lead nurse to implement a new standardised audit to include a routine battery check. The batteries were replaced and on our return unannounced inspection, we saw that staff had immediately started to record daily checks of the batteries whilst they awaited updated paperwork to use in daily audits from the resuscitation team.
- Bed spaces in the CCU complied with the Department of Health's Health Building Note 00-09, which dictates a minimum standard of space for effective infection control. The escalation bed spaces in recovery did not comply with this requirement as space was restricted but this area was only ever used temporarily when the CCU was operating at capacity. However this still presented an elevated risk of infection to ITU patients.

- Senior clinical staff were working on a programme to improve equipment standardisation across the trust's hospitals, such as the supply of identical syringe drivers. This was intended to improve efficiency in the supply, cost and maintenance of equipment as well as to improve training for staff when they moved between departments and sites.
- The facilities in the relatives and visitors waiting area needed some attention, including repairs to damaged chairs and a cleaning schedule for a water fountain.
- We found that a cleaner's cupboard used to store chemicals was unlocked because the key had been lost. We found two used mops had been left standing in dirty water which was not compliant with local cleanliness policy.
- The unit was not compliant with the Department of Health Management and disposal of healthcare waste regulation HTM 07-01 that requires hazardous waste to be disposed of in orange bags. Instead we saw such waste disposed of in yellow bags, which should be used for non-hazardous hygiene waste. This presented a risk to waste disposal teams if they handled the bags improperly on the assumption that the contents adhered to Department of Health guidance.

**Medicines**

- Staff protected patients from the risks associated with the unsafe use of medicines through the use of effective administration that complied with the Faculty of Intensive Care Medicine and Intensive Care Society guidelines and the Medicines Act 1968 and the Misuse of Drugs Act. We observed staff administering medication and noted that appropriate checks were carried out first. Staff used the aseptic non- touch technique (ANTT) following the best practice guidance of The Association for Safe Aseptic Practice.
- We observed a nurse preparing and administering an IV antibiotic. The process did not follow the Health and Safety (Sharps Instruments in Healthcare Regulation) 2013, a European directive applied to all healthcare providers. This was because the required yellow additive label on the diluting fluid bag had been replaced by a sticky white label locally, which we were told was normal practice.
- Medicines were stored in a secure, temperature-controlled room, that staff checked and documented for safe temperature twice daily. A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance. Where staff had identified a break in the 'cold chain', the need for continual refrigeration of an item, appropriate action had been documented. Medicines stored for the purposes clinical trials and research were stored in locked cupboard, stored and administered separately. Controlled Drugs (CDs) were stored in a locked cupboard, which the nurse in charge held keys to. The nurse in charge, along with a qualified nurse, checked drug stock every night and this was supplemented by a three-monthly pharmacy audit.
- A dedicated pharmacist conducted a monthly rotation of medicine stock, which was complemented by weekly stock checks by a healthcare assistant (HCA). This was documented in a medicines record book. We noted that there were two gaps in the weekly checks in the previous month and found that some items, including sterile water for irrigation, a glucose testing solution and a container of sodium chloride had passed its expiry date. There were four containers of patients' own medicine stored in the medicines room that was for patients who were no longer on the unit or that had expired. This meant that staff involved in medicines stock management and disposal had not been acting in compliance with the standard operating procedure for this process.
- Four containers of insulin had been opened in the medicines fridge but had not been labelled with an open date. This meant that staff could not be sure of the product expiry date and that this had not followed the guidance of the standard operating procedures for the handling and storage of medicine.
- Stock rotation and control appeared to be inconsistent with the department's policy of moving the oldest packaged medicine products to the front of each shelf. We spoke with a senior nurse who followed the appropriate procedure to return the expired medicine to the pharmacy and submitted an incident report to trigger an investigation. A review of medicine checks for the previous year indicated no similar problems and we considered that there was no risk to patients due to the checks staff conducted before administering medicine directly to patients.
- PDNs and the consultant had introduced a robust system to minimise medicine errors and to address these if they occurred. After such an incident, the staff member involved would be offered medication error

training and asked to complete a reflective exercise that would help them to understand what caused the error. We found that such reflection had resulted in staff identifying circumstances that could cause distraction as well as the identification of areas in which they would benefit from refresher training.

**Records**

- We found patient records were detailed, fit for purpose and included evidence of personalised care and multidisciplinary input that adhered to the guidance of the General Medical Council (GMC) and the Nursing and Midwifery Council. Patient records and clinical notes were created and stored using a paperless electronic system that was compliant with GMC Confidentiality (2009) guidance. We looked at a random sample of 17 patient notes and we observed how these were reviewed and updated during two ward rounds. Staff noted communication with relatives and subtleties in a patient's behaviour or outlook were noted. For instance, during a bedside nurse handover we saw that a nurse had noted a person's change in mood overnight so that day staff could monitor this and spend some time talking with the patient. This was noted in a dedicated section that encouraged staff to promote independence.
- Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protection systems effectively.
- All records we looked at included details of allergies, a daily treatment plan and evidence of daily consultant reviews. Specialist assessments were conducted and recorded appropriately, including for feeding, neurology and respiratory needs.
- Staff had conducted an audit on admission and daily review records in May 2015. They found 100% compliance with records audited on day shifts but problems were found with the level of detail in treatment summaries written in night shift documentation and a re-audit had been planned. It was unclear if the re-audit had taken place.

**Safeguarding**

- Staff had a detailed knowledge of their responsibilities regarding the safeguarding of patients and were able to demonstrate this in practice. For instance, staff had contacted the local authority safeguarding team after becoming suspicious of financial abuse of a vulnerable patient from friends and relatives. Their actions had been timely and proactive and the local authority had been able to work with staff on the unit to protect the person involved.
- Safeguarding policies were up to date and readily available for staff on the unit, who knew where to access them.
- 100% of staff were up to date with safeguarding training at the level approved for their grade and role.

**Mandatory training**

- The PDN tracked the training needs of nurses in the unit and planned ahead to reduce the risk that training would expire. Each member of staff attended an annual essential training day where they undertook refresher training in areas such as safeguarding and manual handling. 100% of nursing staff on the unit had up to date mandatory training.
- Mandatory training had included moving and handling, safeguarding, mental capacity and infection control. Staff spoke highly of their opportunities for training and said that they never felt under pressure to take on more than they could handle. They said that protected time for this away from clinical practice enabled them to keep up to date.

**Assessing and responding to patient risk**

- A band 7 nurse led a critical care outreach team (CCOT) 24-hours seven-days a week. The nurse was supernumerary to the CCU but could be recalled to the department in the event of exceptional pressure on the service.
- A newly appointed cross-site lead nurse for deteriorating patients had conducted an audit of the early detection of deterioration (EDOD) system to identify good practice and areas for improvement. 300 patients were included in the audit and the accuracy of records were found to be 80 – 90% overall. The nurse found that the EDOD procedure was always implemented within 30 minutes of an escalation and was working with the CCOT team to maintain this standard. The lead nurse for the audit had established an EDOD action plan to include a one year re-audit with a focus on cross-site consistency, including the use of accurate early warning scores (EWS).
- We looked at the records of six patients who had been admitted to the CCU from the emergency department

after the EDOD system triggered a review by a CCU registrar or consultant. In all cases patients had been admitted at an appropriate stage of their EDOD score and with the input of the CCOT doctor.
- We observed a consultant responsible for critical care outreach assessing deterioration scores appropriately and accurately, including an appropriate response to increasing pain. Clinical interventions were discussed between a senior physician and a senior nurse and the EWS system was used and documented effectively in such cases.
- Appropriate risk assessments were in place to ensure patients could safely use the garden. Special consideration had been given to access, including the provision of a ramp and wide doors to allow patients who were bedbound into the garden.

**Nursing staffing**

- A team of 55 nurses worked in the CCU, 30 of whom held a post-registration award in critical care nursing. This was above the minimum recommended requirements of the Royal College of Nursing.
- Nursing staff conducted handovers twice daily with the whole team, at 7am and 7pm. We observed two handovers and found them to be structured, detailed and with a focus on personalised care.
- Agency and the hospital's own bank staff were used to ensure that staffing levels remained safe. We saw that temporary nursing staff were required to have a post-registration qualification in critical care and had to provide evidence of their qualifications before starting in the unit. The unit used the same nurses wherever possible to ensure consistency and that the temporary staff were familiar with unit systems, equipment and protocols.

**Medical staffing**

- Eight full time and two part time consultants worked in the CCU, all of whom were either Fellows or Associate Fellows of the Faculty of Intensive Care Medicine, or were eligible to join.
- Consultant cover was provided between the hours of 8pm and 9pm, seven days a week, with three other doctors also on the unit during this period including a senior specialty doctor. Outside of these hours, the CCU was staffed by a senior specialty doctor and a senior trainee doctor with support from an anaesthetist. An ICU consultant was on-call and available to attend within 30 minutes between 9pm and 8am. This met ICS standards for medical staffing of CCUs.
- Nurses we spoke with told us that they were happy with the level of medical cover. One nurse said, "The team of doctors is very supportive. The anaesthetist on call overnight always attends very quickly, I've never had a concern about this."
- A consultant handover took place twice daily, at 8am and 8pm. We found that handovers were well attended and included registrars and other doctors on the unit as well as the outreach consultants and outreach charge nurse. Multidisciplinary ward rounds took place twice daily, at 8am and 2pm. During our inspection on a ward round we observed included feedback from a critical care consultant, a biochemist consultant, an anaesthetist, a dietician, a microbiologist, a pharmacist, the nurse in charge and three other doctors.
- CCU registrars contributed to a hospital-wide handover each evening that included medical and surgical registrars and CCOT doctors. Consultants offered input in this meeting and doctors told us that it worked well to help them understand the position of the hospital in terms of capacity and the risk of escalation of specific units.
- There was a low reliance on locum doctors. Where locums were used in the unit, the lead consultant conducted an orientation and induction with them that was documented, fit for purpose and guided by The Faculty of Intensive Care Medicine standards. Nursing staff spoke positively about this process and told us that they had not experienced any additional pressure because of reliance on locum doctors.

**Major incident awareness and training**

- There was a robust major incident strategy in the unit that included the escalation plan and roles and responsibilities in an emergency. The strategy was fit for purpose and demonstrated how staff would ensure patients would be protected from harm.
- A major incident simulation exercise had been conducted within the year prior to our inspection, which included the simulated use of evacuation equipment and processes.
- Nursing staff had varying degrees of understanding of the major incident plan. One nurse said that their only training had been a video session three years ago but

that they received annual written updates from the senior nurse. All of the staff we talked with could tell us how they would assist in a unit evacuation in case of a fire.

## Are critical care services effective?

Good

We rated the CCU at Wexham Park Hospital 'Good' for 'Effective' because:

- Care and treatment were delivered by a competent and experienced team of consultants and nurses and were based on a range of best practice guidance, including from the RCN, the ICS and NICE.
- There was active engagement with a critical care network that demonstrated a track record of contributing to the improvement of patient experiences and outcomes.
- The CCU mortality rate was better than the national average for similar units. Care bundles were regularly audited as part of an on-going system of monitoring treatment outcomes and best practice.
- Patients were treated by a multidisciplinary team of specialists that included biochemists, a microbiologist, a physiotherapist and a CCU dietician.
- Staff managed pain relief effectively and patients' nutrition and hydration needs were closely monitored.
- There were effective systems in place to ensure that staff at all levels understood the need for consent before providing care or treatment, and awareness of the Mental Capacity Act (2005) was excellent amongst the staff we spoke with.

### Evidence-based care and treatment

- A CCU consultant was the lead for sepsis care bundles and audits, including the evaluation of severe sepsis screening tools and acute kidney injury outcomes. A band six nurse had developed a dedicated sepsis lead role that included responsibility for embedding good practice from sepsis audits across the unit. Staff were proactive in the development of sepsis lead roles and had attended a December 2015 sepsis road show to share their learning. The sepsis care bundle was based on the best practice guidance of the Surviving Sepsis Campaign.
- Staff in the unit were active with the Thames Valley and Wessex Critical Care Network. Medical and nurse leads had contributed to regular meetings with this network and had established or contributed to a care bundle group, an education and development forum, a rehabilitation group and a patient transfer group. Learning from this relationship was delivered to staff through study days, lunchtime learning sessions and notices on a staff education board.
- There was a protocol for the transfer of patients to home from the unit if wanted to die at home. This was compliant with ICS guidelines for the limitation of treatment for adults requiring intensive care treatment.
- There was an on-going programme of local clinical audits based on the needs of the unit and individual professional interests. We identified 27 separate audit cycles in place, each managed by a named, dedicated member of staff. The results of the audits were quality-checked by a senior doctor or nurse and an action plan agreed by the audit lead. Results were presented to colleagues during study days, staff meetings or lunchtime study sessions. In most cases a re-audit would be planned at an appropriate future point in time to check progress against the action plan. .
- Staff had completed an audit of chest drain insertions and thoracic ultrasounds, which had should that the unit was compliant with British Thoracic Society guidelines. Staff also completed monthly audits of the tracheostomy care bundle, which scored 100% compliance in September 2015 and consistent compliance scores of 90% or above since January 2015. The September 2015 audit of the ventilator associated pneumonia care bundle showed 100% compliance. An audit into the effectiveness of the hypothermia care bundle had exceeded its target of 33 patients and a cross-trust working group was assessing the results to identify potential improvements in practice. A future re-audit was planned to evaluate the efficacy of improvements and changes in guidance.
- A nurse had led a research programme into the optimal use of a nasal optiflow device. The results had shown that in some circumstances the need for intubation could be reduced, which would result in a reduced stay in the unit. This demonstrated that staff were active in ensuring their practice was based on the latest available evidence.

### Pain relief

- Staff used a combination of verbal and non-verbal assessments to manage pain. We saw that pain scores were documented hourly within electronic patient records by staff who demonstrated an excellent understanding of how pain could be assessed through personalised communication. For example, staff skilfully interpreted the facial expressions of a person who was ventilated when they asked about pain, ensuring that the person was still understood despite not being able to talk.
- Nurses used a rapid escalation process to a doctor if a person's pain increased, which we saw working in practice.
- The discharge protocol included consideration of pain management during the transfer of patients to the ward, including the option to liaise with the acute pain team. Staff liaised with the relevant pain nurse and ensured that patient-controlled analgesia and epidural charts were prepared. Staff had access to local guidance on pain relief for patients with dementia and learning disabilities. This included modified communication protocols such as visual methods and liaison with the hospital dementia lead.

**Nutrition and hydration**

- A dietician was based in the unit for two and a half days each week. Staff told us that this recent appointment had significantly improved their ability to provide specialised dietary input to patients. The dietician attended a 2pm ward round when they were on site and were available by bleep at other times.
- The dietician and a nurse conducted a nutritional assessment of each patient on admission and thereafter at regular intervals depending on patient condition. The electronic patient records system included fluid balance checks, which we saw were used appropriately.
- Our review of clinical notes showed us that staff used the Malnutrition Universal Scoring Tool (MUST) to identify those at risk of malnutrition. Waterlow scores were assessed and appropriate clinical interventions for the avoidance of malnutrition and pressure sores were implemented.
- The hospital's nutritional guidelines were due for an annual review and we were told that they would be updated as soon as new national guidelines were published, which were expected imminently. Work was underway to establish a nutrition assessment for patients being discharged from the CCU and the dietician had begun to work with their counterpart at another of the trust's hospitals to establish this.
- Protocols were in place for total parenteral nutrition (TPN) and percutaneous endoscopic gastrostomy (PEG) feeding tubes and staff had received appropriate training in their use.
- Staff could order hot meals on demand from a third party supplier and told us that they had received no complaints about this from patients. Relatives we spoke with told us that they enjoyed the food that had been provided.

**Patient outcomes**

- The average length of stay for patients was 5.8 days, which was impacted by two patients with exceptionally long stays of over 90 days each.
- The mortality rate in the unit between April 2014 and March 2015 was 22%, which was lower than the national average for units of a similar size and case mix. The mortality ratio for the unit was within the expected range for its size and it was not an outlier in any mortality criteria that is nationally comparable.
- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The unit had variable rates of unplanned readmissions within 48 hours in the 2013/14 and 2014/15 reporting periods when compared to similar units nationally. From April to June 2015, unplanned readmissions accounted for between 1% and 4% of patients.
- From April to June 2015 the rate of early deaths was consistently below 3% of admissions which was better than the national average for similar units. In the same period, the number of people who were discharged from critical care to another ward in the hospital and subsequently died there was about the same or less than similar units.

**Competent staff**

- Junior doctors on the unit were given competency-based training on joining the unit. This included the completion of the Acute Life Threatening Events Recognition and Treatment (ALERT) course within their first two days and Intermediate Life Support (ILS) and Advanced Life Support (ALS) certification

within their first year. There were four dedicated ALERT faculty nurses in the senior nursing team who delivered the training to new staff throughout the year. We saw that doctors also completed the Oxford advanced trauma course and a level one ultrasound course for chest assessments.

- A consultant ran clinical simulation training at Wexham Park Hospital for new doctors. This included intubation techniques and clinical decision-making for deteriorating patients.
- Nurses had received regular supervision and 100% of staff nurses had undergone an appraisal in the last year. Nurses told us that their team leaders were readily accessible and that supervision sessions were focused on their personal and professional development. We looked at an anonymous sample of staff appraisals and found them to be positive and motivational. For instance, staff were praised for good performance in specific circumstances and were supported to develop their auditing and clinical skills.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work in each handover. Staff were asked if they had a preference as to which patient they were allocated to. This served the purpose of offering staff the opportunity to gain experience in treating particular conditions whilst enabling the senior nurse to ensure that staff were allocated appropriately based on their level of experience.
- There were systems to ensure staff were competent to carry out their role. This included an induction programme that ensured new staff were familiar with local policies and procedures, particularly in relation to standards of patient assessment and record keeping. PDNs monitored nurse competencies on a rolling basis to ensure that nurses maintained currency in practice based on national benchmark standards. The lead consultant monitored the training and audit programmes of doctors to ensure that learning was implemented to improve practice. Regular meetings, such as M&M and governance meetings with the critical care delivery group, were used to review practice guidelines and identify areas of good practice and areas for improvement.
- A senior nurse told us that staff nurses were responsible for ensuring their own competencies were up to date but that the senior team kept track of this as well, through the maintenance of staff training and competency records. The senior team offered guidance and support to more junior nurses to ensure they remained compliant with competency requirements set by the Faculty of Intensive Care Medicine. Each nurse in the unit was encouraged to take on responsibility for a specific area of development and learning. This covered all mandatory areas of training such as infection control, health and safety and delirium. Nurses were encouraged to take up areas of professional interest to them and had resulted in lead roles for areas such as blood transfusion, students and mentorship and the ITU follow-up clinic.
- Junior doctors worked in the CCU as part of a rotation programme with anaesthetics and were unable to take leave during their ITU placement. Seven senior doctors and four registrars supported junior doctors as part of a seniority system that staff told us worked well and ensured that patients were always cared for by the most appropriate member of staff for their needs.
- Nursing staff had access to on-going specialised training that was managed by a dedicated practice development nurse (PDN). Nurses we spoke with told us that they were very happy with the standard, frequency and quality of training and that it helped them to develop their clinical skills. Nurses who were interested in progressing to their next band were offered shifts with a clinical supervisor to develop their management skills.
- Trauma training for nurses included specialisms such as the care of patients with traumatic intracranial aneurisms, intermediate life support and advanced life support for hyper acute trauma.
- All newly qualified staff nurses undertook a preceptorship course that was delivered according to the Department of Health Preceptorship Framework. The preceptorship is a transition tool used to support newly qualified nurses in their initial year in the intensive care environment.
- Doctors in the unit undertook work-based assessments as part of the Oxford Deanery Intensive Care Medicine Programme of training, ensuring that their practice was evidence-based in accordance with national standards.

**Multidisciplinary working**

- Appropriately qualified and experienced staff ran a CCOT 24-hours seven-days a week. A CCOT consultant

was available between the hours of 8am and 6pm Monday to Friday. Outside of these hours, a CCOT nurse could refer a patient to the on-call anaesthetist or the doctor in charge in the CCU.
- The practice development nurse had produced a discharge checklist for staff to use to ensure that appropriate multidisciplinary teams were engaged with. This included communication with the appropriate pain nurse, tissue viability nurse and CCOT. We saw that this was followed in practice during our observations of ward rounds and handovers.
- A daily multidisciplinary (MDT) ward round took place that we observed was well attended by a multidisciplinary team of specialists, including a pharmacist, a dietician, a biochemist consultant and a microbiologist. The lead consultant openly encouraged feedback and input from every specialist for each patient and treatment plans were updated accordingly to reflect the MDT input.
- Staff had a thorough understanding of external MDT relationships for patients who would be discharged soon, such as the need for a nursing home for one patient and active liaison with another hospital nearer a patient's home where they wanted to be transferred to. A counselling service and community mental health services were also available to staff to assist with discharge planning. Staff we spoke with were positive about both services and said that they helped to calm patient anxiety before a move and to help their transition into another service.
- During the handover, staffing and patient levels were discussed and it was confirmed that the staff to patient ratio met RCN guidelines. Availability of the CCOT team and supernumerary staff was confirmed and the times of planned procedures for patients were confirmed and contact with multidisciplinary colleagues was discussed, including a learning disability nurse who had been called to help staff with a patient.

**Seven-day services**

- A consultant intensivist provided a seven day service in the CCU and was available in the unit for 13 hours per day, from 8am to 9pm. Outside of these hours, a consultant was on-call and available to attend the unit within 30 minutes. An anaesthetist is available nearby overnight and a senior specialty doctor ensures continuous medical cover.
- A dietician had recently been recruited and was available for 2.5 days per week, with a hospital-wide on-call dietician available at other times. Microbiology, pharmacy, biochemistry, palliative care, organ donation and physiotherapy services were all available 24-hours, seven-days through an on-call system.

**Consent and Mental Capacity Act (including Deprivation of Liberty Safeguards)**

- Staff adhered to the systems in place to protect people from the risks associated with providing care and treatment without appropriate consent. Our review of patient notes found that in all cases consent to treatment had been obtained and documented wherever possible prior to treatment and whenever a patient's condition changed. An initial capacity assessment had taken place with each patient and we saw that best interests decisions had been made appropriately, including the input of mental health professionals and the guidance of the Mental Capacity Act (2005).
- Staff also routinely re-assessed capacity whenever a person's condition improved, in line with the guidance of the Mental Capacity Act (2005).
- Staff had access to best practice guidance and local mental capacity policies on the unit, including guidance for the administration of medicines to patients who were not deemed to have capacity.
- All of the staff we spoke with were able to talk confidently about the Deprivation of Liberty Safeguards (DoLS) and how this could impact a patient in the unit. Staff spoke positively of their training in DoLS and one staff nurse said that although they rarely saw such an authorisation in place, they showed us where the unit's DoLS protocol was stored for quick access.
- Staff had engaged with the Alzheimer's Society to better understand how to communicate with people with the disease and guidelines on vision perception difficulties in people with dementia. This helped staff to understand the risks associated with moving and walking about. Staff used the 'This is me' tool for patients with dementia that included a life history and information such as 'what makes me feel better?' was included. Staff had access to a dementia lead in the hospital and annual dementia awareness days had been offered to ensure staff remained up to date with changing guidelines.

# Critical care

## Are critical care services caring?

**Outstanding** ☆

We rated the CCU at Wexham Park Hospital 'Outstanding' for 'Caring' because:

- Staff demonstrated tireless and inspirational dedication to patients' comfort and emotional needs and showed exceptional drive to empower patients to maintain daily tasks and routines that were important to them.
- Our conversations with staff and relatives and our observations of care revealed a strong and consistent track record of exceptional service. We found numerous specific examples of how staff had gone out of their way to ensure the provision of highly personalised care and treatment programmes.
- Relatives and visitors were cared for by a team of nurses and doctors who understood the anxiety that an ITU stay could cause. The staff approach to dignity and privacy were embedded in the service, including the importance placed on obtaining consent before providing care and the use of curtains during assessments.
- Friends and Family Test results consistently scored the unit with the maximum rating for positive care and recommendations.
- We found numerous areas of innovation that had significantly and positively affected patients and their relatives above and beyond expectations:
- A special project had created a peaceful garden for patients and their relatives. The garden had been conceptualised by a former patient and had been constructed by volunteers from Crossrail, using a community charitable fund and in collaboration with clinical staff. This demonstrated an innovative approach to improving the wellbeing and emotional needs of patients because staff in the unit recognised the opportunities in delivering collaborative care beyond clinical need.
- Staff used innovative visual aids to indicate a person was receiving end of life care ensured that staff and visitors maintained a quiet and respectful presence in that area.

**Compassionate care**

- Staff in the unit encouraged patients and their relatives to take part in the Friends and Family Test, an NHS England initiative to understand the experience of patients and relatives using NHS hospital service. With an average response rate of 65% of patients or one of their relatives, the unit had received consistently excellent scores, with 100% of respondents stating that they were happy with their care in the unit from November 2014 to August 2015, other than in two months with no data submission. We were not able to find an explanation for the gap in data.
- Staff demonstrated a tireless and on-going dedication to treating patients and their relatives with dignity and respect, above and beyond the basic requirement for privacy.
- A senior healthcare assistant had been appointed as a dedicated dignity and privacy coordinator and had introduced an innovative visual dignity system for patients at the end of life. This involved the placement of large, colourful picture of a butterfly on the outside of their bed space curtain. The butterfly emulated peace and was a visual reminder to staff and visitors to be particularly quiet and sensitive in that area. Staff had piloted the system in the unit and had received positive feedback from relatives, particularly as the use of a butterfly could be used without religious or cultural connotations. We saw the butterfly system in use and noted that it was an effective tool in practice to trigger an enhanced degree of dignity and awareness in the area.
- Staff used the RCN Spirituality in Nursing Care guidance as well as RCN guidance on staff responsibilities following a death to provide care that was sensitive. A nurse had compiled an information guide to cultural and religious beliefs in the unit that helped staff in the event that a person had specific religious needs following their death. This included guidance on the roles of different spiritual leaders and instructions to staff on what to do if a person needed to be buried or cremated at a certain time of day. Senior staff we spoke with were able to explain how this was used in practice, such as when a patient of Jewish or Muslim faith died on the unit and there were specific religious needs to adhere to.
- Nursing staff used handovers to discuss patient needs beyond their medical diagnosis or need. For instance, it was discussed if a patient had experienced a restless night or if they were anxious and what staff had done to

assist them. Staff had a high degree of understanding of individual needs and it was clear to us that compassion was very much a part of the handover process. For example, one patient had difficulties understanding or speaking English and staff had met their relatives and found the most appropriate individual to assist with communication. This had assisted the patient in reducing their anxiety at being in the unit. In another case staff had been able to agree a reduced reliance on an oxygen mask for a patient who found this distressing and uncomfortable.

**Understanding and involvement of patients and those close to them**

- Two senior nurses had taken the lead in a project called the Promoting Independence Programme to ensure that CCU services promoted the independence of people. Details of the project were displayed in the unit and included a range of evidence of its positive impact on staff and patients. As part of the project, nurses worked with patients who would be in the unit for an extended period of time to establish a daily routine to help them feel secure and relaxed. This had included facilitating religious practices, reading about train models and watching the news once a day. The focus on peoples' likes, dislikes and emotional needs was evident at all stages of their care and the enthusiasm of staff had a demonstrably positive impact on them.
- Each patient's bedside included a whiteboard that had listed their plans and goals for during or after their recovery, included the names of their nurses and doctor. Staff told us that part of this programme was to promote clear communication with patients and relatives to reduce anxiety and thus speed recovery. On admission, each patient had an 'activities of daily living' assessment that staff used to help them understand each person's ability to perform tasks that were important to their independence.
- From our review of patient notes, we saw that the 'This is me' tool was used consistently and that staff had made efforts to ensure details recorded were appropriate and could be used in practice to help provide individualised care. For example, staff had recorded the sleeping preferences of a person that included which side they liked to sleep on and what they hoped to do when they left the CCU. Staff had paid attention to detail and it was clear that they placed great value on the aspirations of people, for example a patient was being supported and encouraged to be well enough to attend a relative's wedding. The 'This is me' tool is more commonly used in social care services for patients with dementia. However, critical care staff had applied its use to patients in the ITU to help staff get to know them and to help patients feel more understood and involved.
- We spent time speaking with the relative of a patient who had been in the CCU for an extended period of time. They told us how happy they were with the care and treatment their family member had received. They said, "I'm always given a full explanation by staff of anything that's going on. I feel very welcome here and I'm always comforted and reassured by staff whenever I need it. Most important, the nurses are always encouraging my [relative] to speak for themselves to me, rather than letting the nurses speak for me." One relative said that the noise on the unit was sometimes excessive. We identified the source of this as a delivery chute arrival point that was placed near their bed. When a canister arrived, it made a loud noise, which staff said that they were unable to mitigate.

**Emotional support**

- A CCU nurse had established a lead role for patient experience and ward follow-up and conducted visits to people after they were discharged to the ward to check on their progress and wellbeing.
- Nurses from the CCU ran a follow-up clinic for patients who had been discharged, as part of an on-going programme of emotional support. The clinic was run on an outpatient basis and the MDT staff who had provided patient care all attended. The follow-up clinic had proved to be popular and we saw that many attendees had written reflective poems or personal essays on their journey through the ITU, which were on display for patients, staff and visitors to read.
- Relatives we spoke with said that they were aware of the quiet room for their use and that staff were very good at offering them refreshments.
- There was a counselling service available to patients and staff 24-hours, seven days a week. Staff spoke highly of this and said that counsellors were accessible and very understanding of the needs of the ITU.
- There was a well-kept, peaceful garden accessible directly from the ITU. Staff showed us a portfolio of photographs that had been kept of the garden's construction as a project between a former patient,

their professional colleagues who had acted as volunteers from Crossrail and the unit's staff. The planning and construction of the garden represented a collaboration between Crossrail staff and clinical CCU staff to ensure the garden could be used safely by patients. We saw the garden used during our inspection and were aware of the positive impact this had on patients' emotional state. Patients were able to use the garden even when ventilated and we saw that doctors and nurses had appropriate risk assessments and protocols for movement in place to facilitate this.

- Staff noted communication with relatives and subtleties in a change of patient's behaviour or outlook in their records. For instance, during a bedside nurse handover we saw that a nurse had noted a person's change in mood overnight so that day staff could monitor this and spend some time talking with the patient. This was noted in a dedicated section that encouraged staff to promote independence.

## Are critical care services responsive?

Good

We rated the CCU at Wexham Park Hospital 'Good' for 'Responsive' because:

- Staff constantly sought out strategies to ensure patients' individual needs were met, including for patients with communication or language barriers, dementia or learning disabilities. A wide range of resources were available to staff to help them in the delivery of specialist care.
- Delirium and sedation were monitored appropriately by staff using nationally recognised tools.
- Relatives and visitors were provided with a quiet room and an en-suite bedroom for overnight stays, which had capacity for two people.
- The admission, period of treatment and discharge processes were particular focus areas for staff and the low number of out-of-hours or non-clinical transfers compared favourably similar units on a national level. An escalation plan was in place that enabled staff to use two additional bed spaces in the nearby recovery unit if the CCU was full. This had resulted in a substantial improvement since our last inspection.
- The complaints process was effective, with investigations including the appropriate input of patients and relatives. Issues arising from complaints led to changes in systems and practice.

**Service planning and delivery to meet the needs of local people**

- Staff were aware of the needs of the local population and had secured additional training for nursing staff in the provision of care to people with alcohol or drug-related organ failure and an alcohol liaison post had been created to support nursing staff
- Staff said that they were experiencing an increasing number of patients who needed bariatric care and the matron was preparing a business case to purchase appropriate equipment for this to reduce the need for renting such items.
- Staff were equipped to provide a service that met people's needs outside of the clinical treatment plan. Religious and cultural needs were provided by staff who had access to a comprehensive portfolio of advice from national religious organisations to help them to provide care that met the needs of individuals.
- Advice was accessible by staff on the unique needs of people based on sexual identity and for those who were experiencing domestic violence.
- Staff were active in discussions of organ donation with patients and relatives. The NHS Blood & Transplant Special Health Authority had sent the team positive feedback for their responsiveness and contribution to positive outcomes from a case of lung, heart and kidney donation.

**Meeting people's individual needs**

- The staff team were dedicated to ensuring that people could be cared for appropriately regardless of their individual needs and demonstrated a commitment to adapting the service that showed passion and innovation. For instance, a senior nurse had compiled a learning disability resource folder to help staff communicate with patients. This included a 'traffic light' assessment tool that could be completed so that other staff would understand what was important to know about the person. There was also a visual communication pack that included large, bright images that staff could use to help them communicate with people.

- Patients were assessed for their level of delirium by staff who used the Confusion Assessment Method (CAM) and the Richmond Agitation Sedation Scale (RASS), which was repeated every two hours. There was a draft sedation policy in place that was due to be presented to the hospital board for ratification. The use of the CAM and RASS methods was effective and appropriate.
- Staff had taken the initiative to lead on areas to improve patient experience such as by securing TV sets as part of a charity donation drive and helping a former patient to refurbish a secluded, peaceful garden that encouraged reflection and was accessible to all patients in the unit.
- The overall drive to promote independence amongst patients included simple but important factors that made people feel valued and more relaxed. For instance, patients could have their hair washed and styled, a homeopathic therapist visited the unit regularly and patients were encouraged to use the garden. Staff were able to facilitate this at any time, including where patients required significant support from equipment.
- There was a quiet room available for relatives and visitors and relatives were also able to stay overnight in a well-appointed bedroom with en-suite shower facilities.
- Patients had access to freely available and up to date information in the waiting area and on request from staff. Printed information was available to explain to relatives and patients what they could expect in the unit, how to make a complaint and the visiting hours policy. The waiting area also had a large, easy to understand staff plan that included photographs so people would recognise staff and their role. The display included details of who was in charge of each shift and a whiteboard near the ITU entrance that displayed the numbers of nurses on shift compared with how many were planned. We found that this degree of transparency in communication with people was reflected both in the information available to people on displays and in leaflets and in the way staff interacted with them.

**Access and flow**

- Proposed admissions to the unit were reviewed by a consultant and CCOT staff could make urgent referrals. The CCOT consultant was able to provide rapid assessments during working hours and outside of these the on-call consultant and anaesthetist would provide this.
- There had been 347 delayed discharges of four hours or above in the period April 2014 to March 2015, or 54% of the 644 patients treated. This was in line with similar units nationally.
- Non-clinical transfers out of the unit had increased from quarter four 2014/15 to quarter one 2015/16 and there had been no occurrences since April 2015. Staff told us that the numbers had increased previously due to high occupancy rates and that the escalation policy enabled them to safely assess patients prior to and during a transfer.
- Out of hours discharges, or discharges occurring during the hours of 10pm and 5am, were below the national average from April to June 2015. Doctors in the unit had conducted an audit on out of hours transfers in early 2015 and had disseminated their findings to the rest of the unit as learning to reduce occurrences.
- The theatres recovery unit was equipped to provide space for CCU patients as part of an escalation plan if the main unit was full. The consultant used an established escalation protocol if the recovery beds were needed and this would only be implemented if safe levels of staffing could be achieved. If the recovery spaces were used, CCU nurses would accompany patients and would use a mobile PC to ensure that patient monitoring systems were the same as in the main unit. A portable ventilator was available for use and one of the escalation bed spaces had an anaesthetic machine. This meant that staff had access to the same equipment as they were used to in the main unit. If a level three patient was in the recovery area, one of the CCU nurses deployed would always hold a post-registration award in critical care.
- We spoke with a doctor in the recovery unit about the impact this would have on the department. They told us that the impact was minimal if both CCU spaces were in use, other than a minor limitation of space on one of the other beds.
- Senior nurses told us that the summer 2015 period had been exceptionally busy and that staff had worked continuously under intense conditions without a break in the flow of patients. From February 2015 to May 2015, occupancy of the unit had been above 85%, which is the maximum figure set by national occupancy guidelines. The unit had also seen an increase in the acuity of patients, which had resulted in more frequent use of agency nurses and a new nurse recruitment drive.

# Critical care

**Learning from complaints and concerns**

- The matron had an enthusiastic approach to learning from complaints and this was reflected in the discussions we had with staff. Formal complaints on the unit were rare and staff were confident in speaking with relatives who had minor concerns or issues. When a complaint was received, members of staff involved were consulted in the first instance and the details were discussed through monthly team meetings and monthly directorate meetings. We reviewed the minutes for such meetings for the six months leading to our inspection and saw that they enabled staff to learn from each other and to share best practice.
- We saw that were a complaint had been made, the investigation and response processes were robust and in the best interests of the complainant. For instance, a complaint that had been received from a relative who had been asked to leave the unit while treatment was administered had led to a meeting between the consultant, matron and a patient relations representative. Learning had taken place from this meeting and we saw that when people were asked to leave the unit, a more detailed explanation was offered and that staff had a greater awareness of the needs of visitors. The meeting was recorded onto a CD for the relative so that they could be confident of the process that had been used to address their complaint.
- Following feedback from visitors, staff wore different coloured uniforms that indicated their grade and seniority, to help people identify them more readily. A noticeboard at the unit entrance displayed the uniform colour associated with each grade.

## Are critical care services well-led?

**Outstanding** ☆

We rated the CCU at Wexham Park Hospital 'Outstanding' for 'Well-led' because:

- There was a clear and credible vision and strategy that staff talked about confidently and with examples of how this applied to their work. The leadership and culture within the service had resulted in high rates of staff retention and professional development, with a continuous programme to ensure that staff at all levels were involved.
- There was a well-respected, coherent and highly visible leadership team in the unit. Staff told us this was effective and conducive to a positive working environment. Nursing staff said that the medical team and senior governance team were approachable, responsive and collaborative in how they communicated and considered changes to working practices. We found a focus on development and improvement at all levels of the service, led by enthusiastic practice development nurses and a matron who was held in high regard by all of the staff we talked with.
- Significant focus was placed on the sustainability of the service and on securing staff retention. There were low staff turnover and sickness levels, indicating a stable team. We found numerous examples of outstanding practice with regards to supporting nurses' development, including a management development programme and evidence of positive encouragement for nurses to lead on projects such as writing new policies and developing local audit tools.
- We found high levels of staff satisfaction across all roles and all staff told us how proud they were to be part of the unit team and that they felt strongly that there was never any intimidation, harassment or bullying.

The critical care service demonstrated a number of exemplary and innovative features to support its objectives:

- A critical care delivery group managed pilot projects and business plans to expand and sustain the service, and staff told us that they were consistently listened to and encouraged to submit ideas and feedback.
- Nurses could contribute to the running of the service and had ample opportunity to develop themselves professionally under performance management arrangements that were proactive and systematic.
- As part of the unit's focus on improving patient outcomes through safe, innovative research, staff had the opportunity to work in collaborative teams and received robust support from senior staff for this.
- Challenge was readily accepted by the senior team, who demonstrated a robust approach to investigating problems and complaints and readily included staff and patients in such investigations.

**Vision and strategy for this service**

- The hospital had recently been acquired by Frimley Park Hospital NHS FT. Staff told us that this had had improved their understanding of the strategic direction of the department and felt that the trust's values were relevant to them. One senior nurse said they were happy that senior staff, "…haven't tried to force change that isn't needed. They're focused on retaining the staff we already have and recruiting high quality new people who will want to stay with us." Senior staff on the unit had discussed how the trust's vision could be applied to their work in the unit whilst still contributing to the hospital as a whole. Staff told us they felt that the overall focus very much applied to them and they were able to adapt this to the needs of their patients as well as their professional development.
- Managers were preparing a business case to convert one of the medical wards into a medical acute dependency unit, which would reduce pressure on the CCU and improve access and flow. A business case was being prepared by the critical care delivery group for the increase of capacity and improvement and flow. This was indicative of the broad focus on service development and improvement we found in all of our discussions with staff.
- The associate director of the unit and the matron discussed future plans for the department that centred on increasing capacity by converting large storage rooms at the end of the CCU into more bed spaces. This formed part of the unit's own strategy that staff told us they felt a part of, including being given the opportunity to discuss future expansion plans during meetings.
- Staff told us that the vision and strategy for the unit was driven by a strong and growing research profile as well as by the successful focus on person-centred care beyond immediate medical treatment needs. The innovation demonstrated by nurses in facilitating patient requests such as visits home, improved access to the garden and the provision of complementary therapies were part of a sustained and enthusiastic programme of individualisation for the unit's portfolio of care delivery.

**Governance, risk management and quality measurement**

- The CCU was overseen by the associate director of theatres and the chief of service, who had worked for the Frimley Park Hospital.The Chief of Service and associate director were responsible for critical care, anaesthetics and theatres. The unit's head of nursing also had responsibility for surgery and the operation of the unit was led by a dedicated matron and a consultant intensivist.
- We spoke with the senior leadership team responsible for the CCU, including the chief of service and lead consultant. They told us that their main concerns about the continuity of service were related to capacity, medical staffing and the CCOT service. In all cases, mitigating policies and practices were in place to reduce the risk to the service and its patients. These included the use of an escalation plan for capacity problems, responsive bed management strategies and the ability to redeploy staff based on skill mix and competencies. Staff also had long-term plans to address the issues, such as a business case for converting storage space into a clinical environment, a new recruitment process and a new medical decisions unit.
- Senior staff held monthly directorate meetings with clinicians and senior nurses to discuss risks and governance issues in the department. We looked at a sample of minutes for recent meetings and saw that discussions were focused on identifying good practice and establishing this as a benchmark for staff. We saw that the input of staff was acknowledged and used to discuss improvement action plans, with the contributing staff member involved in the process. The chief of service also met with the chief executive officer regularly to discuss strategies for governance issues.
- Senior staff maintained a risk register for the unit that identified risks in all areas of the service, including in areas such as facilities, staffing and access to MDT services. Risks were assessed according to the potential impact on patients and the service and actions were allocated to a responsible individual. We saw that the risk register was updated regularly with tasks evidenced, such as the employment of a dietician to the unit to address previous risks associated with relying on dieticians off-site. The key risks identified by the senior team related to a need for more band five nurses and an increase in capacity to reduce out of hours and delayed discharges. Each risk had an accountable owner and we saw evidence of regular progress updates to them, such as an improvement in staff retention through more robust induction processes, a business plan to expand the capacity of the unit and an escalation plan to reduce the number of non-clinical transfers by utilising bed space in theatre recovery.

# Critical care

### Leadership of service

- The senior team in the unit were acutely aware of the need to support and nurture their nursing team. Staff we spoke with told us, without prompting, how proud they were to work in the unit and how happy they felt with the level of management support. We were told that this was a holistic approach and not just when they were on clinical shifts. For instance, one senior nurse had been supported to take up a research lead post and nurses taking a management development programme were offered a new job title of senior staff nurse. This contributed significantly to their feeling of accomplishment and successful development and helped to encourage retention on the unit.
- Lines of accountability and responsibility in the unit were coherent and staff were clear of their roles and how to escalate problems. A critical care delivery group had been created to drive forward improvements in capacity, access and flow in the department and was a point of pride amongst the staff we spoke with. A senior nurse told us that it "felt good" to work in a department that not only demonstrated high levels of positive patient outcomes every day but that had tangible, achievable plans for the future.
- Junior doctors told us that they felt the unit functioned well and that the consultants took ownership and gave clear directions to them. One junior doctor said, "I'm really happy to be here. There is no bullying, no belittling and the consultants are really accessible."
- Nurses told us that they thought the strict standards put in place by the senior team helped them to perform well and ensure that areas such as infection control were tightly monitored. One nurse said, "The matron and senior nurses here are natural-born leaders. We're on first-name terms with the doctors; this is an incredibly impressive team to be part of."

### Culture within the service

- Senior nurses in the unit told us that the directorate's leadership team were very much a part of the department and that they felt the director of nursing, the head of nursing and the associate director were all approachable and responsive to communication.
- Staff nurses told us that the culture in the department was one of coherence, stability and mutual support. One nurse said, "We are kind of overloaded with learning opportunities, there are so many programmes on offer it can be difficult to choose. We have a very close, helpful team that wants to share their learning with each other. We're encouraged to contribute to new policies and procedures and one of us recently implemented a new blood collections protocol. We're very much encouraged to take part in every aspect of the unit."

### Public and staff engagement

- From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service. All of the staff we spoke with told us they felt listened to and could tell us who they would approve with different ideas for the service or when they had concerns.
- The unit's research profile was particularly strong and staff were encouraged to participate in this when a project was of professional interest to them.
- Relatives and a patient we spoke with told us that they felt involved in care and treatment decisions and that the level of information given to them was appropriate and very clear. Patients who attended the ITU follow up clinic provided feedback on their experiences in the unit, identifying staff care and discharge procedures as particularly memorable.

### Innovation, improvement and sustainability

- The matron, PDNs and senior staff nurses had an exceptional approach to sustaining their nursing team through a programme of continuous, challenging clinical development. For instance, nurses who had successfully completed a post-registration CCU course were encouraged to undertake a six-month secondment involving management practice to enable them to progress to the next band. Six band five nurses completed this in the three years to our inspection and all of them were still in post. This was cited as good practice in staff retention and has been shared across the critical care network with other ITUs. PDNs also offered secondments to post-qualification nurses into a CCOT role. This process was further supported by a policy of recruiting externally only into nursing bands of five and below. Nurses at bands higher than this were recruited through internal promotion, which resulted in the unit being led by a very experienced, cohesive team.
- The matron had established a system of exit interviews with human resources to track the reasons staff who left

cited as contributing to this. The results from this exercise had been used to improve working conditions and benefits for staff and had resulted in improved retention. The contribution of HCAs was recognised and valued on the unit and pre-registration nurses were able to take the Bedside Emergency Assessment Course for Hospital Support Workers (BEACH) and level four apprenticeships.

- Student nurses from the University of West London were offered placements on the unit, led by a senior nurse.

We saw that investment had been made in looking after student nurses as a strategy to encourage their future interest in working there. Special study days had been delivered by senior nurses to students and we saw from evaluation forms that students were unreservedly positive about their experience. The student nurse programme included a focus on confidence-building that helped students to learn without fear of intimidation.

# Maternity and gynaecology

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Wexham Park Hospital maternity services include a maternal foetal assessment unit (MFAU), an early pregnancy unit, an antenatal clinic, and a triage department that has three cubicles and one consulting room. The antenatal ward has three-four bed bays and two single rooms. Each bay has its own toilet and shower, and there is a bathroom and toilet suitable for wheelchair users.

The labour ward includes 10 dedicated rooms and a birthing pool. There is a quiet room where women can relax in a comfortable chair and surroundings when in early labour. There is a dedicated theatre next to the labour ward for emergency caesarean sections; elective caesarean sections are carried out in the main hospital theatre. From April 2014 to March 2015 there were 4,323 births. There is a midwife-led birthing suite with five rooms including two birthing pools and one postnatal room. Approximately 74 births a month take place in the birthing suite. The postnatal ward has a total of 25 beds; five bays of four or five beds and three side rooms. An extra three-bed dedicated amenity service is available.

The 22-bed gynaecology ward includes three six- bed bays, four side rooms and an additional assessment unit where women can sit in comfortable chairs. The hospital is registered for termination of pregnancy services.

During the inspection, we spoke with 53 staff. They included senior managers, consultants, doctors, supervisors of midwives, midwives, community midwives, nurses and support workers. We spoke with 16 maternity and five gynaecology patients and their family members. We observed care and treatment and looked at 14 care records for maternity and gynaecology patients to track women's journeys from admission to discharge.

# Maternity and gynaecology

## Summary of findings

Overall we rated maternity and gynaecology services at Wexham Park Hospital as 'good'. This was because:

- At our last inspection carried out in February 2014 we found the maternity and gynaecology services to be inadequate. This was because of failure to report incidents and reliance on bank and agency staff to maintain the services. Governance arrangements were poor with inadequate systems for monitoring staff performance and dealing with an inappropriate staff culture. We evidenced that the majority of issues identified in the previous report had been identified and addressed.
- Patients were protected from the risk of avoidable harm and, when concerns were identified staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary, actions were taken to prevent recurrences. Medical, midwifery and nursing staff provided safe care; staffing levels were in line with national averages and were regularly reviewed.
- Staff delivered evidence-based care and treatment and followed NHS England and the National Institute for Health and Care Excellence (NICE) national guidelines. There was multidisciplinary working that promoted integral care. The audit programme monitored whether staff followed guidelines and good practice standards. The previous high caesarean section rate was in line with the national average. Staff were caring and thoughtful, and treated women with respect. Patients' confidentiality and privacy were protected. All the patients and relatives we spoke with gave positive feedback about their care and how staff treated them. Women and their partners felt involved with their care and appropriate explanations were given to them.
- Policies and procedures were available on the hospital's intranet for all staff to access. Appropriate arrangements were in place for patients who could not make informed decisions about their care. Systems were in place to support patients who had a learning disability. Complaints were dealt with effectively and improvements made where necessary. There had been a decrease in the number of complaints made since the previous inspection.
- There were established local governance arrangements and risk management identified risks to patients and service delivery through the risk reporting process. This is a process for dealing with risks, actions taken to minimise them and recognising those that required reporting to NHS England. Staff demonstrated a strong desire to develop the services and efforts had been made to gain the views of patients and the public. The widespread poor culture found during the previous inspection had almost gone. Senior managers were working towards eliminating poor practices. Many improvements had been made and staff had an open and motivated attitude that had strengthened the culture throughout. Senior managers had developed a plan to sustain the improvements and continue improving the quality of the services.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good

We rated maternity and gynaecology services at Wexham Park Hospital 'Good' for 'Safe' because:

Following the previous inspection, a staffing review was carried out across all grades. Improvements to medical, midwifery and nursing staffing arrangements ensured there were enough skilled and knowledgeable staff to meet patients' needs and peaks in service demands. Staff reported and recorded incidents and managers investigated them. This enabled teams to understand the causes and to improve the safety of services. The corridors, departments, wards and clinical areas were visibly clean and uncluttered.

Processes for safeguarding, assessing and responding to risk were appropriate and there was a system for the escalation of concerns. There was a dedicated safeguarding team. Staff had attended mandatory training in addition to other safety-related development opportunities. Technical equipment was readily available. Medicines were stored, managed and administered in line with the NHS Regulations and The Medicines Act 1968 guidelines.

### Incidents

- Clinical staff were aware of the reporting process for incidents, near misses and never events. A never event is a situation that arises when safety measures are not followed correctly.
- There had been no reported never events during the past year. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented). There were 18 serious incidents requiring investigation. Four of these related to unexpected admissions to the neonatal unit.
- We spoke with staff of all grades in the maternity and gynaecology departments; they were familiar with reporting practices.
- There was a system in place to report adverse events, accidents or near misses. The electronic system used was known as Datix and all staff we spoke with said they had access to this.
- The reporting system showed that themes were identified and discussed at regular multidisciplinary meetings. Minutes from the obstetrics incident review group meeting held on 10 September 2015 told us that all incidents were discussed and rated by degree of severity. In-depth investigations were carried out for serious incidents. If immediate concerns were identified about a member of staff, they were followed through by their line manager. The concerns were also escalated to the assigned supervisor of midwives to monitor the individual midwife's clinical knowledge and performance.
- All staff received feedback about outcomes from serious incidents and the resulting actions that needed to be taken. This enabled them to learn from serious incidents and helped in preventing the same thing from happening again. Staff of all grades who we spoke with told us they received an email about the results; these were also available on the intranet and published in quarterly newsletters. Outcomes of serious incidents were also posted on a notice board in the staff room of the labour ward.
- Senior staff held regular meetings to identify where trends had occurred and to put systems in place to prevent similar occurrences. They also monitored whether the required actions had been addressed.
- The minutes of monthly Governance meetings informed us that the actions taken and lessons learnt were of an appropriate standard to prevent recurrences.
- Quarterly safety meetings were held to review incidents and ensure safe measures were in place.

### Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecology (RCOG) in October 2014. This is a system of reporting on harm-free care that covers a range of areas including admissions to neonatal units.
- Each clinical area in maternity and gynaecology collected information as part of its safety monitoring. This included incidents relating to perineal and

abdominal trauma (complications following surgery), post-partum haemorrhage (excessive blood loss following delivery), infections, pressure sores acquired in hospital and falls.

- The service took part in the national maternity dashboard, which measured outcomes. The dashboard data was regularly compared with safety-related targets. The indicators used included the percentage of caesarean sections and other assisted deliveries (where forceps or a suction cup (ventouse) were used to assist delivery of the baby's head). They also included clinical outcomes – the results of patient's care.
- 'Harm free' care is defined as the absence of pressure ulcers, falls, catheter associated urinary tract infections and venous thrombosis. The monthly results were discussed during monthly governance meetings. For July 2015 the performance for the gynaecology ward was 98.1%; this compared with the national target of 95%.

**Cleanliness, infection control and hygiene**

- The environment where women received care was visibly clean and tidy. We saw daily and weekly cleaning schedules for staff to follow.
- Clinical staff followed their own cleaning routine. For example, cleaning of medical equipment to ensure it was appropriate for use. A large range of 'once only' equipment was used and disposed of after use.
- We observed cleaning staff had the recommended colour coded cleaning equipment for use in different areas. This minimised the risks of cross contamination that could lead to patients picking up infections.
- Monthly audits of each clinical area were recorded. The results were added electronically to the central audit. Identified improvements were allocated to appropriate staff who were given timescales to complete them.
- The audit for the gynaecology ward for June 2015 gave a result of 90% for staff hand hygiene and 93% for general hygiene. The target was a minimum of 80% achievement. From April to June 2015 most maternity areas had scored 100% for hand hygiene. For example, ante natal clinic and the foetal assessment unit.
- We spoke with a senior sister who told us they regularly carried out spot checks and if they found an area that required attention they brought it to the attention of relevant cleaning staff.
- People who used the services said they were satisfied with the standards of hygiene.
- There were plenty of sinks available where people could clean their hands. Hand hygiene gel dispensers were prominently displayed in all non-clinical and clinical areas to encourage staff, patients and visitors. Staff were observed to follow good practice regarding uniform and dress code. They complied with the criteria of being bare below the elbows and wearing only permitted jewellery.
- Handling of clinical specimens and clinical waste procedures including segregation, storage, labelling and transferring were appropriate in preventing cross contamination.
- Personal protective equipment (PPE) such as gloves and aprons were readily available in each clinical room to promote hygiene. Staff we spoke with told us there were always adequate supplies.
- All staff including cleaners were expected to attend infection control and prevention training when they commenced employment.
- Staff had access to infection control policies and procedures. Staff we spoke with told us they were accessible on the hospital intranet.

**Environment and equipment**

- Emergency clinical equipment such as resuscitation, oxygen and suction equipment was stored appropriately so that it was available for use at short notice. It was checked each day to ensure it was in working order. We saw recordings to confirm this.
- Cardiotocography (CTG) electronic equipment was used to monitor the foetal heartbeat and uterine contractions during labour. The midwives we spoke with told us there were enough CTG machines available to cope with demand and they were and regularly checked to ensure they remained in working order.
- The areas where women received their care were noted to be suitably laid out and afforded privacy for times when discussions were held in supporting them with their care needs.
- We spoke with staff from various departments within the maternity and gynaecology services. They told us they had adequate supplies of medical equipment. Equipment had been serviced and calibrated to ensure it remained fit for use. Staff told us that repairs of medical equipment were treated as a priority.

- Senior managers were conducting an on-going review of medical equipment replacement. We saw a midwife with a brand new piece of medical equipment.
- Portable appliance testing (PAT) had been periodically carried out for all movable electrical equipment such as kitchen equipment.
- Emergency equipment for pregnancy related complications was accessible to enable staff to provide immediate care. This included pre-eclampsia (a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine) and postpartum haemorrhage kits.
- Resuscitaires, used to support new born babies who may need extra warmth or resuscitation after delivery, were available in the labour ward and other clinical areas. These were checked daily and records made to support this.
- An electronic tagging system was in use for babies to ensure they did not leave the hospital before discharge.
- The labour ward and wards had restricted access. Access was by a coded lock or buzzers to request access by staff to protect patients' privacy.
- Maternity wards visited were very tired and in need of investment with some maintenance issues i.e. damaged floors, walls and seals with some bad smells. The wards were clean but generally in poor condition.
- The emergency equipment on the gynaecology ward was appropriately stored and checked regularly. The ward was clean and tidy but spacing between beds in the main areas was limited and restrictive for staff when providing patient care.
- Both male and female public toilets sited on the corridor were both in poor condition having damaged floor and wall coverings and the décor is also poor. Foul smells emanate from behind the damaged fabric of the toilet.
- Several hot water temperatures were in excess of the maximum allowed 42 degrees centigrade (temperature were recorded between 56 degrees C & 59 degrees centigrade) a potential "scalding temperature" these water outlet temperatures should be regulated as a safety precaution.
- All the maternity ward sisters interviewed were asked about the service received by estates. They all said the service was good but sometimes slow.

**Medicines**

- We reviewed the systems for managing medicines and processes for ordering, storage, administration and recordings. Deliveries were made twice each weekday from the pharmacy department. Pharmacy staff regularly visited the clinical departments and wards to check that the stocks were adequate. Staff could also request extra supplies.
- Staff in the ward areas carried out daily temperature checks of the medicine fridges and these were recorded. This ensured that medicines were stored at an appropriate temperature to maintain their stability.
- There was access to emergency medicines, such as those used for allergic reactions and for treating low blood sugars to prevent further complications.
- Drug errors were said by staff to be reported via the incident reporting system and were reviewed under the normal incident process. Minutes of an incident meeting we saw confirmed this.
- Controlled drugs were stored correctly within a wall mounted locked cupboard and staff regularly checked the numbers of each drug against the recordings. These checks were recorded and signed by two staff.
- A supply of paper prescription pads were stored in the labour ward. They were kept in a locked cupboard. Recordings were kept of the numbers stored and when a prescription was issued.
- Midwifery and gynaecology staff recorded errors in medicines management and administration and these were analysed for trends.

**Records**

- We reviewed 14 sets of care records in various areas of the maternity and gynaecology services. These had been completed with relevant current and previous clinical information. There was detailed information where explanations had been given when patients requested a different treatment to that proposed my medical staff. All recordings had been dated and signed.
- There were some standard clinical recording tools such as, a request for induction of labour, labour pathway, World Health Organisation (WHO) checklist (a nationally recognised tool to reduce errors occurring in theatres) and theatre records. Regular audits of the WHO checklists were carried out and the latest audit result was 96.7% achievement.
- Recordings had been made of medicines administered and when and any post-delivery interventions required.

- Women carried their own pregnancy records, which were brought into the hospital and these were supported by hospital-held information to ensure staff had a full history.
- Detailed recordings were made regarding the assessments of babies shortly after birth and further notes had been made during the length of the hospital stay.
- On discharge, women were given written information and relevant contact details in case they needed extra support.
- As part of monitoring staff practices supervisors of midwives carried out regular audits on the content and standard of recordings made by midwives. Where poor practice was identified, processes were put in place to rectify it.

**Safeguarding**

- There was a designated safeguarding lead and a safeguarding team who dealt specifically with patients assessed as being at risk of harm and protected babies before and after birth. The safeguarding team provided additional support for women during their pregnancy and hospital stay.
- Community midwives assessed the vulnerability of women during the antenatal and postnatal periods. Safeguard alerts and areas of concern were recorded on the maternity system. Members of the safeguarding team were available to provide advice and to take appropriate action within the community and the hospital.
- Staff were aware of the female genital mutilation (FGM) guidance. We observed how staff cared for and treated a woman during their stay in the labour ward. We noted that all attempts had been made for the provision of sensitive care that met the patient's personal as well as health needs.
- All clinical staff had attended safeguarding training that was relevant to their role. Refresher training was part of the mandatory annual workshop. Staff were also encouraged to access e learning courses. The training data confirmed that all clinical staff had attended the workshops.

**Mandatory training**

- A tailored induction course was attended by all newly appointed staff. The course included mandatory training courses such as, perineal suturing, risk management, breech presentation and maternity theatre skills. The induction included dealing with emergencies such as, shoulder dystocia and cord prolapse.
- All medical and midwifery staff attended annual refresher training. For support workers it included bladder and catheter care, post-operative care, observations, record keeping and accountability. Medical staff and midwives attended a two-day workshop that included safeguarding, diabetes in pregnancy, mentorship and dealing with emergencies.
- Qualified bank staff were expected to keep up-to-date with their training needs. We were told that they attended the annual mandatory workshop. We met with one of the five practice development midwives who told us that if bank staff failed to attend training courses they were not rostered to work until they did.
- Data informed us that 96.9% of staff were up to date with their training. Exceptions included recently recruited staff and those on long term absence.
- A practice development midwife was rostered to work weekends each week to provide leadership and support. Their roles were split into 50% clinical work and 50% administration and teaching workshops.
- Trainee doctors told us they were given a good amount of training, engagement and opportunities to learn from various cases.

**Assessing and responding to patient risk**

- Women were assessed in the triage unit. If it was closed the phone was automatically transferred to the labour ward. Staff were skilled in recognising women who were at risk, such as, those whose rhesus negative blood type was a threat to the baby. These women had received immunoglobulin to improve outcomes for the baby.
- We saw clear recordings that identified the safest method of delivery for each woman. The recordings told us that the rationale for the method of delivery had been discussed with each woman and their agreement recorded. We saw recordings where due to a change in the health of women and safety of the baby the method of delivery had been changed, sometimes at short notice. The women we spoke with told us they had been kept well informed during their pregnancy and labour. Other women explained to us why they required an elective caesarean section.

- Staff said they had been trained in the modified early obstetric warning score (MEOWS) to recognise women who were becoming unwell. We saw that staff used the system correctly.
- Babies were monitored before birth using cardiotocography (CTG) when necessary. CTGs monitor the baby's heartbeat and the strength and frequency of contractions during the first stage of labour.
- Regular meetings were held with all clinical staff and junior doctors invited to attend. During these meetings, in-depth analysis of a number of CTG results took place, the resultant actions reviewed and improvements identified for future occasions. Discussions were held to determine if the actions taken were appropriate or whether other actions would have been more effective.
- The service used neonatal early warning systems to record observations to enable staff to respond when there were signs of deterioration.
- Women who had a general anaesthetic for a caesarean section remained in theatre until they were fit for discharge from the recovery area. Upon return to the ward they were cared for and their health monitored by staff who had been trained for this purpose. Care notes included recordings confirming that appropriate monitoring had taken place for each woman.
- We observed good multidisciplinary working between the neonatal and obstetric staff with the theatre team. Staff followed the world health organisation (WHO) surgical safety checklist pathway to reduce the number of surgical errors and promote patient safety.
- There was an early detection of deteriorating (EDOD) patient system used within the gynaecology service for identifying when a patient required assistance.
- The care records we looked at in the maternity and gynaecology units all included fully completed risk assessments about any areas where concerns had been identified women's health.

**Midwifery staffing**

- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, is one whole time equivalent (WTE) midwife to 28 births. This is a system for ensuring sufficient staff availability to provide safe care. Data from the hospital dashboard informed us that the maternity service had a ratio of one WTE midwife to 30 births.
- When women were in established labour they received one to one care until delivery of their baby.
- Bank staff and permanent staff from other departments were available to assist during busy times and to cover during staff absences. When staff from the birthing unit did not have women to care for they also provided help in the labour ward.
- The Head of Midwifery (HoM) and their deputy told us they worked in the clinical areas during peak periods. This influenced the ratio of midwives to the number of births.
- Staff told us that women received one to one care when they were in established labour. From observations during the inspection we confirmed this.
- Recruitment and retention rates had improved since the previous inspection in February 2014. Senior managers had carried out a staffing review to ensure the staffing levels matched the needs of patients. As at June 2015, there were 5.96 WTE midwife vacancies and the use of agency staff had ceased in April 2014.
- A registered general nurse was employed to provide care and monitor the health of women when they returned from theatre following a caesarean section. We spoke with the nurse who told us how they supported women. They were not involved with obstetric care as this was provided by midwives. Health Care Assistants (HCA) and band three support workers were employed to provide general and limited clinical care and to support midwives.
- We spoke with a range of staff of various grades in the maternity and gynaecology service. They felt that there were sufficient staff and during busy periods they all worked together to ensure patient's needs were met appropriately.
- We spoke with the matron of the gynaecology service. They told us they could usually find enough cover during sickness absences and that when necessary they also worked shifts. Bank staff could also be approached. We observed that a member of permanent staff agreed to cover a shift.
- When cover could not be found from permanent staff in the antenatal ward, birthing unit or postnatal ward bank staff provided cover.
- Monthly retrospective statistics were recorded for midwifery and gynaecology staffing and the results compared with the agreed skill mix. The report for June 2015 stated that a 96.8% appropriate skill mix had been achieved.

# Maternity and gynaecology

### Medical staffing

- The medical staff skill mix was consultants 33% compared with 35% national average. Middle grade doctors (at least three years' experience at senior house officer level or a higher grade with their chosen speciality) were17% compared with an 8% national average. There were 45% registrars employed compared with 50% national average. Junior doctors made up 5% of the workforce compared with 7% national average. Overall, the numbers of medical staff matched the national average.
- Minutes of the hospital Quality Committee meeting dated September 2015 informed us that from May to August this year inclusive there was 98 hours of consultant presence in the labour ward per week. This was in line with the guidance of the Royal College of Obstetricians and Gynaecologists (RCOG). Consultants were present on the maternity unit during daytime hours each day and were on call from their home at night.
- During our inspection, we observed that senior, middle grade and junior specialist medical staff were on duty on the maternity unit from 8am until 10pm seven days a week. As well as a consultant there were two specialist doctors and junior doctors allocated to cover the labour ward and the gynaecology ward. A junior doctor worked until 5pm on the antenatal and postnatal wards and another works in the triage unit. Staff told us that senior medical staff always responded when their presence was requested. A range of doctors remained on call within the hospital to enable them to respond promptly when needed.
- Midwives, nurses and junior doctors we spoke with told us that senior medical staff responded when their presence was requested.
- There was dedicated anaesthetic consultant cover for the elective caesarean section list and another for labour ward.

### Major incident awareness and training

- Staff were aware of the RCOG guidelines, which included the potential closure of the maternity unit, with contingency planning to ensure that any decision to close the unit was appropriate. The unit had been closed on two occasions in the past year.
- There were other policies available to staff on the hospital intranet for dealing with major incidents such as, abduction.

## Are maternity and gynaecology services effective?

Good

We rated maternity and gynaecology services at Wexham Park Hospital 'Good' for 'effective' because:

Women's care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation. A range of audits were carried out concerning care and treatment to identify where improvements could be made to staff practices. For example, the high rate of caesarean sections found at the previous inspection of February 2014 of 35.8% had been reduced to 25.6% by July and was 22.7% for August 2015. This compared with 25.5% national average. This was achieved by changes in clinical practice.

Staff were appropriately qualified to carry out their roles. There were opportunities for professional development of staff. Trainee doctors told us they were well supported and received good training. There was an effective supervision and appraisal system for staff. There was a multidisciplinary approach to care and treatment. Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and the requirement to obtain consent.

### Evidence based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as, the National Institute for Health and care Excellence (NICE) and the Royal College of Obstetricians and Gynaecology (RCOG) safer childbirth guidelines.
- The hospital was following RCOG guidelines on antenatal tests for low-risk women.
- Midwives who worked in the midwife-led birthing unit followed NICE and the Royal College of Midwives guidelines.
- The care of women who planned for or needed a caesarean section was seen to be managed in accordance with NICE Quality Standard 32. This included evidence in records reviewed and from discussions with medical staff.

# Maternity and gynaecology

- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support that every woman, their baby and their partner should expect to receive during the postnatal period.
- There were policies and guidelines available on the hospital intranet. The Head of Midwifery (HoM) told us all policies and procedures were being reviewed jointly with the sister hospital to draw upon the best aspects and to ensure consistent working practices.
- There was an audit programme in place in the maternity and gynaecology services, which was informed by national guidance, patterns of incidents and clinical data outcomes. For example, postnatal re-admissions, operative vaginal deliveries and third/fourth degree tears were being audited. Regular audit committee meetings were held to review data and implement changes.
- Gynaecology audits were routinely carried out regarding Rapid Access Referrals (RAR) (two week appointments for suspected cancer). The RAR result for May 2015 was 95% and 100% of diagnosed patients had their treatment commenced within 31 days.
- Monthly multidisciplinary staff cardiotocography (CGT) meetings formed part of audits and evidence based care.
- The results of audits were shared with all staff within the services through the regular newsletter, audit presentations and mandatory training and learning boards. Audits included emergency caesarean sections, three and four degree tears, obstetric haemorrhage and postnatal readmissions. These were reviewed and where possible changes made in staff practices.
- The results of the gynaecology data were monitored through clinical governance such as colposcopy and oncology services.
- We spoke with a Supervisor of Midwives (SoM) who told us the current ratio of midwives to SoMs was 13.5 midwifes to each SoM. The national requirement is 15 midwives to one SoM. As well as annual audits of midwives records. The previous years' audit involved the standards of recordings made regarding resuscitation. We were told that where concerns were identified that SOMs participate in investigations about midwives practices. Although SoMs did not work weekends there was always one on call at all times to provide guidance and support if requested.

**Pain relief**

- Pain relief available for maternity patients included Entonox (gas inhaled), pethidine and epidural anaesthesia of which there was an uptake of 30%. Patients and staff we spoke with told us there was approximately a daily 30-minute waiting time for anaesthetist availability to set up and administer the anaesthetic. Anaesthetists followed the local protocol when they explained to women the likely pain relief they may need following a caesarean section.
- Women were able to access pain relief as required and in a timely manner. The maternity women we spoke with all told us they could have analgesics when they felt they needed them and they did not have to wait for the next medicine round to take place. Use of the birthing pool also provided pain relief. One was available in the labour ward and two in the midwife-led birthing unit. Women were encouraged to use this facility.
- We spoke with three patients on the gynaecology ward, two of which had been in patients for a number of days. They all told us that staff responded promptly when they required pain relief. We saw that patients who had major surgery were given patient controlled analgesia (PCA) to allow them to control their own pain relief. Before they were given PCA staff explained to them the maximum dosages they could self-administer within a 24-hour period and optimum use of PCA.

**Nutrition and hydration**

- Breast-feeding was encouraged and women supported in successful achievement. The uptake of breast-feeding was monitored on a monthly basis and the average numbers over a six-month period up to September 2015 was 77% at the point of discharge and this was comparable with the national statistics. Babies who had postnatal jaundice were given extra fluids in between feeds to prevent escalation of this short-term condition.
- Patients were assessed for dehydration and where necessary intravenous fluids were started. For example in hyperemesis (morning sickness) and those who could not drink following surgery.
- We asked a range of patients if they were offered enough fluids. They all confirmed that staff had ensured they had adequate supplies of water throughout the day.

- Women on the postnatal ward and gynaecology ward said they were generally satisfied with the standard of the meals. We saw that patients were given a wide range of choices. We spoke with a patient who had been provided with a culturally appropriate meal. The wards included a kitchen area where drinks and snacks were available between meal times.

**Patient outcomes**

- The hospital had instituted a new maternity dashboard since April 2015. It reported on clinical outcomes before, during and after delivery.
- The number of women who had their labour induced (started artificially) varied between 22.7% and 26.5% over the previous six months making an average of 25.9%. This was in line with the national average.
- The national caesarean section rate was 25.5% and improvements had been made so that the hospital rates were comparable at 22.7% for August 2015. The dashboard data for the same month informed that 63.8% of women had a normal vaginal delivery compared with the national average of 60.1%and 12.9% were forceps or ventouse assisted deliveries.
- Also 3.11% of women had a third or fourth degree tear during delivery; 1.04% had shoulder dystocia and 0.26% of women had a postpartum (after delivery) haemorrhage.
- We saw that staff had developed care plans for maternity and gynaecology patients and in some instances these were very detailed and tailored to the individual's needs and included personal preferences including method of delivery.
- Patients who needed specialist care such as physiotherapy were referred by doctors and arrangements were made for the provision of other specialist services if necessary.
- The care plans for patients who had long term conditions or gestational diabetes were developed taking into account their health needs.
- There had been four unexpected admissions to the neonatal unit during the last year and these had been analysed to identify if there were contributory factors.

**Competent staff**

- A comprehensive induction programme for newly appointed staff was tailored to their roles. This included a range of training courses such as care of intravenous therapy.
- Student midwives and newly qualified midwives were supported by a mentor. We were told that this support lasted as long as the individual staff member needed it.
- Health care assistants (HCA) and support workers told us they had training opportunities offered to them such as, babies hearing tests before discharge that had been introduced five months ago. A support worker told us that a new mandatory training schedule had been developed for them and that some staff were currently attending these workshops and there were more who needed to attend.
- With the exception of recently appointed staff, all midwives and registered nurses received annual appraisals. Staff we spoke with told us these included training needs, discussion of issues and setting objectives. The hospital was meeting the 95% target with a 5% non-attendance rate for sickness absences. Trained staff were encouraged to take up development opportunities such as high dependency care.
- Clinical staff regularly held drills to maintain and improve the skills needed in the event of an emergency. This might involve dealing with for example, shoulder dystocia, cord prolapse, breech presentation (unusual position of the baby or the cord at the point of delivery) or neonatal resuscitation.
- There was a fully staffed dedicated theatre team for gynaecology surgical procedures and caesarean sections.

**Multidisciplinary working**

- There were team handovers on the labour ward twice a day during staff changeovers. Medical staff and the co-ordinating midwife participated in these. We observed a handover and noted that it was comprehensive.
- We saw positive interactions between staff in the labour ward for a patient who needed surgical intervention to deliver their baby. We noted good communications with neonatal staff who were to be present for the delivery. There was a positive relationship between staff on the postnatal ward and the neonatal unit regarding the progress of babies who were on the unit and the likelihood of their transfer to the postnatal ward.
- We listened to a handover on the postnatal ward. A printed sheet containing women's details and care

needs was used for this process. We observed positive interaction between staff so that there was a good understanding of each woman's and their baby's needs for the remainder of the day.
- Hospital staff maintained communications with community midwives who also came into the hospital to speak with staff. We were told that staff contacted health visitors when they needed to pass on information.
- Staff told us they could access the vulnerable women's team known as 'Crystal'. The team had direct involvement in the care and welfare of women as soon as pregnancy was diagnosed and it continued care until after delivery.
- Other support for women was arranged for them as required such as an assessment by a dietician or a tissue viability nurse.

**Seven-day services**

- Consultants worked seven days a week from 8am until 10pm and they were supported by registrars and junior doctors. On-site medical cover was provided during other times. A consultant carries out foetal medicine ultrasound scans.
- A consultant was on call out of hours to provide support for junior doctors.
- The triage unit operated between the hours of 8am until 10pm. During other hours women were assessed in the labour ward.
- Radiology staff remained on-site until 8pm each weekday. They were on call during other hours.
- All women with gynaecology concerns could report to the hospital via the emergency department.
- Weekend cover for the gynaecology ward was provided and emergency admissions were assessed upon their arrival.

**Access to information**

- Midwives told us and we saw from looking at records that information from community and antenatal clinic appointments were available to women. Information was also stored electronically. Women's medical and obstetric history was recorded for staff to consider when there were concerns about pregnancy, labour and during the postnatal period.
- Staff were able to access guidelines electronically to assist them in delivering effective care and treatment.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We observed patients giving verbal consent before staff provided care or treatment. Women we spoke with in the maternity and gynaecology services told us that staff always asked for permission before providing care.
- We saw that written consent had been obtained prior to surgical procedures and operations. Records we looked at included signed consent forms. The five steps of the World Health Organisation (WHO) checklist had been followed.
- The hospital had set procedures in place for assessing patient's capacity, whether they came into the hospital as an emergency or a planned admission. Staff we spoke with talked confidently about mental capacity assessments within the remit of their role.
- Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) was part of the hospital's mandatory training. Mental health refresher training formed part of the annual mandatory courses.
- Staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

## Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services at Wexham Park Hospital 'Good' for 'Caring' because:

Women and their relatives were positive about the care they had received. Staff were kind and considerate. Women and their partners felt involved with their care and were happy with explanations that were given to them. Women's privacy and dignity were promoted.

Patients on the gynaecology ward were well informed and told us they were well looked after by caring and compassionate staff. Staff spent time with patients to

ensure they understood their health conditions and the care and treatment they required. Patients we spoke with told us they knew about the care they were going to receive and when they were likely to be discharged.

**Compassionate care**

- Women and their partners were very positive about the standards of care they had received.
- All of the women we spoke with told us that they had been treated with kindness, dignity and respect. They commented about how friendly staff were, which improved the general atmosphere on the ward. We saw good interactions between staff and relatives.
- We observed staff respecting women's dignity by knocking and waiting to be invited into the room. Staff waited outside curtains and asked for permission to enter.
- We saw staff in various departments and wards discussing patients' needs to ensure they received care and treatment in a way that was appropriate for the individual.
- The Friends and Family Test (FFT) results were generally better than average for standards of care. From January to July 2015, ratings for antenatal care were 96% to 100%, birth experience was 100% each month, postnatal care was between 90% and 99% 93% to 100% for the postnatal community midwifery period.

**Understanding and involvement of patients and those close to them**

- Women we spoke with during the antenatal period said they had been given choices about birth and where they wished to be.
- When women with complex needs who attended the antenatal clinic the assigned community midwife made efforts to also attend. This was so that they had a clear understanding of what had been said by the doctor. This enabled the community midwife to discuss in detail birth options to ensure that women understood their care and could make appropriate decisions.

**Emotional support**

- Birthing partners were encouraged to stay which provided extra support to women and facilitated early bonding for the family unit.
- One midwife had specialist knowledge in bereavement. During the inspection we were informed that there were plans to refurbish the bereavement room and 15 members of staff had been trained in the provision of bereavement support.
- There was a designated bereavement room for parents to access and maintain their privacy.
- We spoke with three patients on the gynaecological ward. They said they were happy with the surgical and nursing care they had received. They told us they had been involved in the decisions made and staff were helpful by taking time to explain their health needs.
- A nurse from the gynaecology ward told us they offered counselling to arrange services to assist women in coming to terms with their condition and circumstances.

## Are maternity and gynaecology services responsive?

Good

We rated maternity and gynaecology services at Wexham Park Hospital 'Good' for 'responsive' because:

Patient flow through the maternity unit enabled women to access the service at each stage of their pregnancy. On the days of our inspection we saw some good examples of how staff responded to women who had complex needs and those who needed urgent assistance. The care records we looked at informed of clear pathways for access to appropriate services. Women who had an elective caesarean section were given a date to enable them to make preparations.

Gynaecology patients had access to services and appropriate expertise. There were arrangements to support people who had restricted mobility. Where possible staff acted as translators and the services had access to a telephone translation service. We saw that complaints process was understood and when received were dealt with effectively and in a timely way. The number of complaints received had gradually decreased since the previous inspection in February 2014.

**Service planning and delivery to meet the needs of local people**

# Maternity and gynaecology

- The hospital offered early pregnancy assessments, the foetal assessment unit, antenatal clinics, a triage unit, scanning sessions and gynaecology clinics. We spoke with staff who carried out the scans. They told us they were very busy and at times 'stretched' by the number of scans they were expected to carry out.
- Some women seen in the antenatal clinic experienced a long wait before they were seen. Senior managers told us they were aware of this issue and were discussing a way to tackle the problem. However, women we spoke with said they were happy with the care they had received.
- There was a dedicated antenatal clinic for women who had gestational or long-term diabetes to enable their health needs to be addressed in conjunction with their pregnancy.
- The hospital employed labour ward co-ordinators who were partially supernumery to ensure the smooth running of the labour ward and allocated midwives to women. They regularly assessed the staffing levels against the anticipated workloads and when necessary allocated more bank midwives to work in the labour ward. The staffing rotas that we reviewed confirmed that changes had been made to meet anticipated demand in keeping women safe.
- Community midwives offered an on call service to support women who were planning to have a home birth. Women were given an informed choice about where to give birth depending on clinical need.
- High-risk women were seen by medical staff within one hour of their arrival in the labour ward.

**Access and flow**

- We were told about the positive ease of access to care including appointments, information and advice. Low risk women could access the midwife-led birthing unit.
- Community midwives carried out home assessments and home deliveries.
- The availability of scans out of hours and access to theatres further enhanced the service. Staff reported that there was 24-hour access for women who were bleeding during their pregnancy.
- The maternity unit had been closed on two occasions during the previous year and alternative arrangements had been made for women at another local hospital.
- There were dedicated theatre sessions for planned caesarean sections.
- The bed occupancy for the maternity unit ranged between 79% and 87% during the year. This was above the national average of 55-60% occupancy. We asked staff if they experienced bed shortages and were told that this had not happened. Women were discharged early after delivery unless there were health needs that required attention for them or their baby. Women who had caesarean sections also went home early. The women we spoke with on the postnatal ward said they were happy with the arrangement.
- During the inspection, the 22-bed gynaecology ward had eight surgical and four medical outliers (non-gynaecology patients). The ward accepted urgent admissions; the outliers could affect this service if they experienced a bed shortage for gynaecology patients.
- The outpatient service comprised of a common waiting area that was shared between maternity and gynaecology services.
- The midwife-led birthing unit provided single room facilities. We were informed about the plan to build a transitional care unit in the birthing unit to enable women to stay with and care for their baby after discharge from the neonatal unit. This gives women the guidance and time to feel confident before they were discharged.
- The labour ward rooms were appropriate for their intended use and provided a safe environment.
- Women on the postnatal ward could breast feed behind their curtains or use a large room where women could breast feed in private. The room was also used to carry out babies hearing tests before they were discharged from hospital.
- An area of the gynaecology ward had been refurbished and opened the same week as the inspection as an assessment unit. This included comfortable chairs where women relaxed who were likely to be discharged the same day. For example, we spoke with a woman who was being hydrated after excessive hyperemesis (morning sickness). They told us they were comfortable and well cared for and appreciated the lack of need for bed rest.
- Clinical areas such the antenatal and postnatal wards included toilet and bathing facilities for use by wheelchair users.
- The triage unit consisted on three cubicles and one consulting room. However, the area was cramped and cubicles did not afford women's privacy.

- The three six bedded bays on the gynaecology ward resulted in beds positioned very close together. However, this restricted privacy and ability to hold confidential discussions. There were side rooms but these may be fully occupied.

**Meeting people's individual needs**

- Women received care from the same midwife in the community for the majority of their pregnancy and following birth.
- There were arrangements in place to support women who had complex needs, with access to clinical specialists and medical expertise.
- Staff recognised that patients who had a learning disability needed extra time and care. Family involvement was encouraged. For in-patient stay a side room was allocated and an extra bed provided so that a relative could remain with the woman to reduce their anxiety. When necessary decisions were made using best interests guidance and involving other professionals.
- There was access to specialist staff such as Crystal the safeguarding team and tissue viability services so the individual care needs could be addressed.
- Designated staff members were available to support parents who suffered bereavement. Facilities were provided to ensure bereaved parents had personal time with their baby. Mementos such as photographs were given to parents. Parents were supported in making funeral arrangements and where necessary counselling services were organised.
- We observed the care and treatment provided for a woman in the labour ward who had complex needs. Staff responded promptly by developing a comprehensive care plan that met the woman's sensitive personal needs and their health needs. We saw that staff adhered to the care plan to ensure the woman did not experience unnecessary distress.
- Leaflets were available in the antenatal clinic, the antenatal and postnatal wards that provided further information including the contact details of support groups.
- Postnatal bookings with community midwives were routinely made by staff when women were ready for discharge. Written details about this and the care they could expect to receive in the community. We observed a discharge and noted that the written information including contact details were explained fully to the woman before they left the ward.
- Section 1 (1) of the Abortion Act 1967 (as amended) and the Abortion Regulations 1991 (as amended) require that two doctors provide a certificated opinion, formed in good faith, that at least one and the same ground for a termination of pregnancy as set out in the Act, is met. Clinical staff followed the Department of Health Guidance in Relation to Requirements for the Abortion Act 1967.
- The hospital had developed written protocols and written guidance about the procedure, what women could expect including full explanations, after care and funeral options. We were shown the checklist that had been developed to ensure that clinical staff covered all aspects of the requirements.
- The hospital did not carry out surgical terminations. Clinicians offered women a termination of pregnancy when foetal abnormalities were found. From April 2014 until April 2015 14 medical termination of pregnancies had been carried out.Consent had been sought prior to the procedure.
- Following our inspection the hospital was assessed by the Human Tissue Authority (HTA) in November 2015. The result was that the hospital was practicing safe disposal methods. There were three minor actions that hospital staff were required to address.
- Staff monitored the referral to treatment times for the gynaecology service. At the time of the inspection staff had achieved 97.96% achievement for women who were not admitted to the hospital and 97.28% for those who were admitted.

**Learning from complaints and concerns**

- There was information available about how to make a complaint. People we spoke with knew how to raise concerns or to make a complaint.
- Learning from complaints was integrated with the governance arrangements. They included formal review to ensure that appropriate actions had been taken.
- We observed a woman making a verbal complaint about a delay in the service. This was dealt with promptly by the Head of Midwifery (HoM) who explained the reason for the delay, apologised and told the patient

when the delay was expected to end. The woman accepted this. Recordings were made so that staff could monitor if there were trends and to develop action plans to deal with them.

- Since the last inspection in February 2014, improvements had been made to the services. This had resulted in a decline of the number of written complaints received. The rate was three or four per month at the time of the inspection; this was a reduction from six per month.
- Complaints were routinely discussed during monthly governance meetings. The numbers received, details, actions taken, learning points and lessons learnt had been recorded. For example, three complaints had been received regarding the gynaecology service during April and none during August 2015. We saw that outcomes were shared with relevant staff and where necessary changes had been made.

## Are maternity and gynaecology services well-led?

Good

We rated maternity and gynaecology services at Wexham Park Hospital 'Good' for 'Well-Led' because:

Staff told us there had been 'huge' changes and improvements made during the last year. There was a clear governance structure in place and staff told us they were proud to work at the hospital and expressed a strong desire to make further improvements. Senior managers told us that staff had accepted and coped with the changes in a positive and professional way. Senior leaders understood their roles and responsibilities in overseeing the standards of service provision.

A new chief of service across both sites had been appointed. The Head of Midwifery also worked across other sites within Frimley Health NHS Foundation Trust. The directorate had an apparent direction of focus, defined by strategic aims and a vision for the services. Medical staff, midwives and nurses reported positively on the level of engagement and continuous improvement. Staff told us that senior staff were visible and approachable. Senior management had engaged with the public to obtain information about their experience and the standard of services they expected to receive.

### Vision and strategy for this service

- The obstetrics and gynaecology directorate strategy clearly articulated the integration of services across acute and community sites of the organisation.
- There had been an analysis of the strengths, weaknesses, opportunities and threats for varying elements of the maternity and gynaecology services and a plan developed to reflect these.
- The Head of Midwifery (HoM) had developed written guidance for the mechanisms of implementing changes. The document had been ratified dated June 2015. It included consultation and communication processes to ensure all staff were invited to be involved.
- The hospital mission statement was; 'committed to excellence, working together and facing the future. The strategy for maternity services was to further improve the service, provide continuity of care, to ensure the caesarean section rate was consistent with the national average and to carry out some refurbishments.
- We asked staff to describe the vision for the service. They demonstrated that they were fully aware and involved with the changes and plans for the hospital.

### Governance, risk management and quality measurement

- The service had a risk register and details were published in the quarterly newsletter and by emails to individual staff members. The details were fed into the hospital wide risk register.
- Regular multidisciplinary clinical governance meetings were held. The minutes of these suggested that discussions included performance, policy and guidance, complaints and incidents.
- Local governance issues were discussed at various forums including ward and department meetings so that information was cascaded to all staff.
- The risk assurance framework had identified that the pathway for acute gynaecological women resulted in delays in transfers from the Accident and Emergency department to the gynaecology ward. We saw evidence of a proposal to introduce a dedicated acute gynaecology service to address the problem. Whilst plans were being drawn up monthly auditing of the situation was carried out.
- Additional quality meetings were held to review and agree action plans.

# Maternity and gynaecology

### Leadership of service

- Leadership had been strengthened following the acquisition and there was cross trust leadership. There was a clear management structure in place for medical staff, midwives and nurses, which included community midwifery. Doctors that had qualified went on to be consultants and had returned to the maternity and gynaecology services.
- Since the previous inspection in February 2014 a review of all staff and skill mix had been carried out. This included senior management. It resulted in an improved and clear governance structure. The changes resulted in improved staff numbers and they had clearly defined roles and accountability. Staff we spoke with gave positive feedback about the new structure and that they had clear pathways when they felt the need to talk with senior staff.
- Staff told us the management team were very visible and they could approach them to discuss any issues.
- Staff were given opportunities for professional development.

### Culture within the service

- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they delivered.
- Medical staff had support from senior doctors and consultants. They told us they hospital was a good placement and they were provided with wealth of education and training.
- At our previous inspection we had observed a highly dysfunctional department. The culture is now good - they were on the right trajectory. Some staff we spoke with told us they were not aware of any problems. A few staff reported inappropriate behaviour that was restricted to a few members of staff. We raised this issue with senior management who told us they were aware of the situation and had taken some actions and planned further actions to be taken to deal with the problem.
- Maternity and gynaecology staff told us they felt well supported and were positive about the changes that had been made. They were well aware of the targets around patient care.
- There was an openness and willingness to report adverse events and to learn from them.
- Staff we spoke with demonstrated a strong desire to develop the services in offering women evidence based care. They were keen to share ideas with senior staff who were receptive to changes that led to improvements.

### Public engagement

- Efforts were being made to ask the public for their opinions about the services they had received and their thoughts about how improvements could be made.
- The directorate organised an evening event for people to attend. Emails were sent to 1,000 women and advertisements placed in supermarkets. We were informed that no-one turned up.
- Senior managers turned towards established groups to gain information and they told us they were considering linking up with churches in order to obtain information.
- Data from the Friends and Family Test was used to monitor and influence the standards of the services provided.

### Staff engagement

- Staff we spoke with told us there were improved communication systems within the directorate.
- Medical staff, midwives and nurses had been engaged with and consulted with about the earlier and future changes for the service. They spoke positively about the future of the hospital.
- Information was cascaded via meetings, the quarterly newsletter and by individual emails.

### Innovation, improvement and sustainability

- During the inspection the chief executive gave a presentation about the improvements that had been achieved and the plans for the future. They included how they intended to sustain performance, improvements to the infrastructure and getting the right culture.
- The high rate of caesarean sections found at the previous inspection of February 2014 of 35.8% had been reduced to 26.5% by July and was 22.7% for August 2015. This compared with 25.5% national average. Audits had been carried out and improvements made in clinical practice.
- Discussion with three consultants and the HoM described improvements made so far such as a new training structure for all staff and new recruits and review of staffing of all grades including senior staff.

# Maternity and gynaecology

There were systems in place to continue to harmonise with the sister hospital and that this was a three-year project. They told us that staff were involved with proposals for change via implementation of sub teams to work on the architecture of service changes.

- The hospital led on foetal dating training and the gestational optimal foetal weight programme.

# Services for children and young people

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Children's services at Wexham Park Hospital were consultant-led and were located in the children's department. The children and young people's ward 24 had a total of 30 cots, with the ability to accept infants, children and teenagers. The ward consisted of a four bedded assessment bay; five bedded surgical bay; five bedded medical bay; five bedded teenage unit; four trolley paediatric assessment unit (PAU); a double side room; five single side rooms; and an ambulant area with chairs. As well as direct admissions from the emergency department (ED), the ward also facilitated planned admissions; the PAU took direct GP admissions. Ward 24 also took day case admissions, and offered ambulatory care and open access for some patients. Ward 24 had a room set aside for high-dependency care.

Children and young people were admitted for a range of medical and surgical conditions, including oncology, general surgery, plastic surgery, ear, nose and throat (ENT), orthopaedics, urology and oral surgery.

Wexham Park Hospital had a level 2 neonatal unit (NNU) categorised as a local neonatal unit. The level of care provided within this unit allowed for all categories of neonatal admissions, with the exception of babies who required complex or long-term intensive care.

Before visiting, we reviewed a range of information we held about children and young people's services and asked other organisations to share what they knew. We carried out an announced visit on 14-17 April 2015.

During the visit we spoke with over 30 staff on the wards. We spoke with a range of staff including consultants, doctors, nursing staff and support staff.

We talked with three children and young people who use services and six visiting parents. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records. We met with children and young people who use services and their carers, who shared their views and experiences of their care and treatment.

# Services for children and young people

## Summary of findings

Overall we services for children and young people at Wexham Park Hospital 'Good' because:

The treatment and care needs of children and infants were assessed and planned from referral to discharge, taking into account their individual needs. The health and wellbeing of children, young people and infants was monitored using recognised assessment tools. Arrangements were in place for looking after vulnerable children. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs as and when required.

Children who spoke with us said that the staff' were kind and caring and that they received information that helped them understand what treatment and care they were receiving. Staff helped children and young people and those close to them to cope emotionally with their care and treatment. Comprehensive safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding. The service had systems in place to ensure that incidents were reported and investigated appropriately.

Children and young people's services were well-led by a very enthusiastic and committed staff team. The leadership, governance and culture promoted the delivery of high quality child-centred care. There was a clear statement of vision and values, driven by quality and safety, with defined objectives. Staff were aware of best practice guidance for the safe and effective care of children and infants. The service had experienced nursing staff shortages, but were actively recruiting nurses by advertising the vacancies.

### Are services for children and young people safe?

Good

Overall we rated services for children and young people at Wexham Park Hospital 'Good' for 'Safe' because:

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Children and young people's safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and children, young people and their families. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Safeguarding children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification.

Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to children and young people who used services. Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly. Risks to safety from anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

**Incidents**

- The service had systems in place to ensure that incidents were reported and investigated appropriately. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system. There had been 235 incidents recorded on the trust's electronic incident reporting system between 11 August 2014 and 13 April 2015. There had been no never events or serious incidents requiring investigation reported

between May 2014 to April 2015 to the strategic executive information system, (STEIS). Incidents were monitored by the neonatal and children's ward matrons for trends.

- Incidents were standard agenda items at bi-monthly 'paediatric governance meetings.' The bi-monthly meetings were attended by a staff representative from each service area. The minutes of these meetings showed that a record of every reported incident was circulated as a standing agenda item and discussed at the meetings. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings.
- Staff told us that learning from incidents was cascaded to ward staff at team meetings, as well as handovers. We viewed the minutes from the neonatal unit (NNU) staff meeting dated 8 July 2015. The minutes recorded that a theme had been identified in the recording of blood spots. As a point of learning staff had been required to read the protocol and ensure they followed this in practice.
- Staff had access to 'paediatric clinical reporting incident triggers' guidance. This was a prompt list that outlined what staff should report on the trust's electronic incident reporting system. The list had been approved by the paediatric quality and safety group in September 2015.
- The lead nurse received safety alerts and was responsible for taking action to respond to relevant alerts. This included discussion of alerts at the children and young people's clinical governance meeting. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS).
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within children's and young people's services. Incidents were audited on the trust's electronic reporting system.
- The NNU and the children's ward used the safety thermometer to monitor harm free care. This is a nationally recognised tool that monitors how a service performs in providing harm free care. The trust undertook the adult safety thermometer and applied it to children and young people's services. Staff recognised this had limitations with regards to children and young people, but used it to record relevant episodes of harm. In August 2015, the service reported that care had been 100% harm free in the previous 12 months. The monthly results were displayed on wards for staff, patients and visitors to see.
- There is a contractual duty of candour imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'. The safeguarding lead told us the 'duty of candour' was included in the trust's safeguarding training.
- The service held monthly 'morbidity and mortality meetings'. There was rotation of consultants who attended the meetings to ensure all consultants had the opportunity to attend morbidity and mortality meetings on a regular basis. The meetings included: discussions of activity on the high dependency unit (HDU) and neonatal intensive care unit (NICU), transfers of critically unwell children, and morbidity. We saw that the findings from mortality and morbidity meetings had been reviewed by a consultant paediatrician in 2015. Learning from the review was disseminated to staff in the form of a presentation. We viewed the NNU quality committee dashboard review for September 2015 and found that the NNU were meeting the trust target of '0' unexpected deaths.

**Cleanliness, infection control and hygiene**

- The trust was found about the same as other trusts in question 26 of the children and young people survey 2014, "how clean do you think the hospital ward was."
- The ward areas provided a safe environment for children and families which were effective for cleaning

and maintenance. All the areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.

- The ward areas had an ample supply of appropriate toys that could be cleaned safely. Play specialist staff told us that toys in the children's ward were cleaned by them as part of their role. The toy cleaning records we viewed on the children's ward were up to date. Play specialists told us toys were cleaned prior to being taken to children in isolation and cleaned again when they came out of the child's isolation room.
- An established quarterly audit programme was in place for reviewing infection control and cleanliness in clinical areas. For the year to date children and young people's services were fully compliant with national institute for clinical excellence (NICE) standards for infection control, achieving the trust's minimum target of 80%. The children's ward had regularly achieved 100% compliance.
- We saw staff regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. The importance of all visitors cleaning their hands was publicised. However, we observed some parents and other visitors not using hand gels or washing their hands. At the time of our visit, children's and young people's services were achieving the trust's compliance standards of 80% for hand hygiene. We saw that gloves, aprons, and other personal protective equipment (PPE) was readily available to staff.
- There were no reported cases of methicillin-resistant staphylococcus aureus, (MRSA), or clostridium difficile, (C. diff), for children's and young people's services in the past 12 months. Babies on the NNU were screened on admission and re-screened on a weekly basis.
- The service's risk register indicated that there had been a colonisation of pseudomonas in the water supply. The trust had taken appropriate steps to address the colonisation including water sampling and daily flushing of taps. The trust's testing of the water supply indicated that the problem had been eradicated in October 2015.
- A programme of training and assessment was in place for 'aseptic no touch technique' (ANTT). During our visit we observed staff undertaking ANTT correctly. The staff training record indicated that 100% of staff were up to date with ANTT training.

**Environment and equipment**

- The trust was found about the same as other trusts in question 25 of the children and young people survey 2014, "does the ward where your child stayed have appropriate adaptations or equipment."
- Entrances to all children's ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night. On the children's ward and NICU access was granted by a ward clerk at reception during the day and by ward staff at night. CCTV was used to monitor entrances at all children's wards.
- All staff reported adequate access to equipment. However, staff raised concerns about timely access to maintenance. We reviewed a number of items on the wards and saw they had been recently inspected. Equipment was checked on a weekly basis and further checks were in place on the NNU.
- Staff told us there was a lack of an appropriate area on the wards for counselling parents, and this did not comply with standards required by both the Department of Health and the BLISS charter. We viewed the children and young people's risk register and saw this had been added in January 2014. In March 2014 the service drew up plans to reconfigure the ward area and the breast pump room was allocated as the parents counselling room. This was reported to the hospital estates department and a grant application was submitted to BLISS for funding. In the subsequent months we saw that the service had made a number of approaches to estates to provide an appropriate quote. The work was eventually put out to tender in October 2015. Staff said the delays from the estates department had been frustrating.
- The service's risk register identified a risk from the generator not working and resultant power failure. A new uninterruptible power supply (UPS) was due to be installed. The trust had an alternative power supply in place for non-clinical appliances to avoid overloading the power supply.

- The children and young people's risk register recorded that there were no service contracts on Vapotherm equipment. The equipment provided respiratory support. The register recorded that this had been addressed in June 2015 and funding approved from the NNU budget for a servicing contract.
- The trust were undertaking a feasibility study for a sensory room for young children or children with learning disabilities.
- The trust had 'built environment-general function and design considerations,' September 2015, identified that children's and young people's services required, "general brightening up." There were no plans in place to enhance the décor of children and young people's wards at the time of our inspection.
- The children and young people's equipment room had a rotation policy. Equipment was taken in one door, cleaned and covered, and then taken for storage to a separate storage room. Clean equipment had an 'I am clean' sticker applied when it was cleaned. Staff told us they only used equipment from the storage area.
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services.
- The children's ward had up to date medical device inventories. These were managed and updated by housekeeping services.
- We checked the children's ward and the NNU resuscitation trolley. We found that resuscitation equipment was readily available and regularly maintained. Neonatal resuscitaires were checked daily. Nurses were familiar with the trolleys contents and knew how to use, check and maintain them.

**Medicines**

- The trust had a divisional pharmacist for children and young people's services that staff could liaise with and ask for advice. The pharmacist worked across all the ward and department areas; and attended the children's ward and NNU daily, reviewing prescriptions and making recommendations. The pharmacist also regularly attended the paediatric clinical governance meeting and junior doctors meeting.
- The trust's pharmacy distribution manager and matron had undertaken an audit of children's and young people's medicines storage on 15 June 2015. An action plan was in place as a result of the audit. We saw that actions taken by the ward to improve medicines storage were recorded on the audit.
- Medicines were stored safely with room and fridge temperatures checked regularly and recorded. Records viewed indicated that medicines were being stored at the required temperatures. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily.
- Prescriptions were prescribed daily by the registrar and checked by the consultant.
- Medicines reconciliation rounds occurred on children and young people's wards. Medicines were restocked through a 'top up' system, ensuring a continued supply. Out of hours, the hospital had an on-call pharmacist.
- Children's weight was clearly documented and prescriptions were appropriate for the child's weight. We viewed nine children's medicine administration records (MAR). Children and young people's allergies were clearly recorded in their medical records.
- Children's and young people's medicines were audited regularly by the trust's pharmacy. The neonates and children's formulary was regularly updated by the children's pharmacist and consultant to ensure safe prescribing.
- Nursing staff' training in medicines administration was up to date. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council's Standards for Medicine Management.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly clinical governance meetings. Staff were open and reported medication incidents. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.
- The total number of medication incidents from April 1st 2015 to September 30th 2015 were 21 on ward 24 and 12 on the NNU, all resulted in no harm to babies or children. The incidents, with the exception of three, were linked to prescription or administration

errors. As a result safety goals had been introduced. One of the goals was to have zero medication incidents linked to prescription or administration errors; this was achieved in July 2015.

- Medicines incidents were reviewed annually in the children and young people's clinical governance report; this was presented to the trust's board. The report included a report on the learning and actions taken as a result of medicines incidents.

**Records**

- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept confidential on the wards in lockable trolleys in the doctors' office.
- Patients were identified on screens in the nurses' station on the NNU. However, this was visible to people visiting the ward and could have compromised patient confidentiality.
- We looked at 18 sets of notes on the wards and the NNU; we found them to be accurate and legible. Patient Information was easy to find.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. The staff training spread sheet recorded that 100% of staff mandatory training, including information governance, was up to date.
- Leaflets explaining patients' rights to access their medical records were available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000.

**Safeguarding**

- The trust was found about the same as other trusts in question 7, "do you feel that your child was safe on the hospital ward," and question 8, "did you feel safe on the ward." of the children and young people survey 2014.
- The trust had a monthly child protection forum. The forum monitored safeguarding notifications, as well as referrals from social care professionals requesting medical assessments. The forum had standard agenda items including: notifications; serious case/partnership reviews; training; and audits. The forum presented a monthly report to the paediatric clinical governance meeting and produced a quarterly report to present to the trust's board. The 2014-15 report outlined the trust's safeguarding achievements as well as their priorities.
- The trust employed one whole time equivalent (WTE) named safeguarding nurse, band 8A; one WTE named doctor; 0.2 WTE neonatal safeguarding champion; and 1.8 WTE safeguarding administrator. The trust also had a paediatric liaison health visitor and named midwife for safeguarding.
- Comprehensive safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding. The policy was reviewed in August 2015 and ratified by the adult and paediatric safeguarding executive group in September 2015.
- Safeguarding children's supervision was formally provided to the named safeguarding nurse and named safeguarding doctor on a regular basis. Formal safeguarding supervision was also provided to specialist children's staff. The safeguarding lead told us safeguarding supervision was available upon request to all hospital staff.
- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. 100% of qualified nursing staff had completed level three enhanced safeguarding training. The paediatric lead told us 85% of eligible staff across children and young people's services had received level 3 training, with the trust target being 95%. We viewed the safeguarding training programme; this demonstrated that training sessions were in place to ensure that staff across the service were trained to the appropriate level in safeguarding.
- The children and young people's safeguarding named nurses managed complex safeguarding cases and worked collaboratively with other health and social care organisations. The safeguarding named nurse also worked with wards and departments, raising awareness and offering advice and support where necessary. Staff we spoke with told us they would liaise with the safeguarding named nurse if they had concerns.
- The safeguarding named nurse's office was adjacent to the children's ward 24. This meant staff could access the safeguarding team easily whenever the safeguarding team were in the office. Staff on ward 24 and the NNU

had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place with the local authority. The local authority hospital social worker's office was located next door to the hospital's safeguarding team's office. This meant hospital safeguarding staff could liaise with local authority staff on a daily basis.

- We viewed the trust's safeguarding children's report dated 30 June 2015. This recorded that a joint adult and children's safeguarding group had been established. The group met on a bi-monthly basis and included the hospitals safeguarding leads and representatives from the local authority.
- The trust had comprehensive guidelines for staff in regards to female genital mutilation (FGM). The trust's safeguarding children annual report 2014/15 recorded that the identification of FGM had been an area of development for the trust. The trust had a policy of addressing FGM when booking women for maternity care.

**Mandatory training**

- Mandatory training in children and young people's services had 100% compliance. Staff we spoke with confirmed that they were up to date with training, or had dates to attend scheduled training. We viewed the children and young people's staff training spread sheet. This indicated that across women and children's services there was a good level of compliance with mandatory training updates. From viewing the record we saw that staff had access to a comprehensive programme of training, including medicines training and training in the use of specialist equipment; 100% of staff specialist training was up to date.
- Staff had access to both level 1 and 2 safeguarding training via the trust's induction. The trust's safeguarding children report 30 June 2015 recorded that the induction had been developed by the safeguarding team in accordance with the 'safeguarding children and young people roles and competencies for health care staff; intercollegiate document', (RCPCH, 2014'. Safeguarding training was being rolled out across the trust to ensure compliance with the intercollegiate guidance.

**Assessing and responding to patient risk**

- The children's ward used the adults' safety thermometer. The NHS **Safety Thermometer** is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. We saw that ward 24 had achieved 100% harm free care in the previous 12 months.
- The service used a paediatric early warning score (PEWS) system on the children's wards, this was based on the NHS institute for innovation and improvement PEWS system. We spoke with staff, who were aware of the appropriate action to be taken if patients scored higher than expected. We reviewed notes and saw that where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented.
- PEWS documentation was audited on a weekly basis. This involved five children or young people's records being audited on a weekly basis. We reviewed the PEWS audits from July and August 2015. In both months the service had achieved 100% compliance with initial PEWS being completed; appropriate clinically indicated observations and assessments taken on admission, and appropriate actions/interventions taken and documented in response to observations and assessments.
- In case of an emergency within the children and young people's inpatient area, the paediatric resuscitation team would attend. The staff training spread sheet recorded that three band 5, one band 6, two band 7, nurses on the children's ward were trained in paediatric life support (PILS). Another band 6 nurse was trained in advanced paediatric life support (APLS). Staff told us staff skills were considered when organising the staffing roster, to ensure there were appropriately trained staff on every shift.
- The NNU risk register identified a risk that new born and infant physical examination screening programme (NIPE) were not being completed in the first 72 hours on the NNU in accordance with Public Health England guidance. In response the service had introduced monthly audits by nursing staff and a new born check stamp that was recorded in the admission book when completed. The service had introduced a NIPE specific,

measurable, achievable, realistic, time focused (SMART) system in September 2015 for monitoring NIPE checks. Training in the NIPE SMART system had been completed by all staff that were required to use the system.

**Nursing staffing**

- Staff reported that there were sufficient nursing staff to ensure that shifts were filled in line with their agreed staffing numbers. However, this was sometimes based on the use of agency staff.
- The safe staffing dashboard was displayed in the neonatal unit and children's wards. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix at the time of our visit. Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of two registered children's nurses at all times in all children and young people's inpatient and day care areas. Staff had access to a band 7 nurse at all times in any 24 hour period. We viewed staffing rotas for the previous month that confirmed this. Staff had access to a lead nurse or ward matron for twenty four hours, seven days a week, via a joint on-call children and young people and neonatal rota.
- During our inspection staff were very visible, particularly on NNU. Staff and managers told us they met surges in activity by using bank staff that were familiar with the wards areas. As a last resort, agency staff would be used. Procedures were in place to request agency staff. Staff told us that if agency staff were required they would request agency nurses who were familiar to the service.
- The trust informed us that temporary staff must have relevant and appropriate training and experience and provide evidence of being a registered paediatric nurse (RN60) or a registered nurse who was adult trained but had paediatric experience (RN00). The service kept records of temporary staff inductions. The NNU dashboard indicated that there had been a decrease in the number of bank staff used between April 2015 and July 2015. There were no temporary staff on shift at the time of our inspection.
- Staff told us that staffing levels in the NNU were safe. The matron told us that flexible staffing meant that staffing levels were managed on the NNU. We viewed the NNU 'planned vs actual' staff spread sheet. This indicated that actual staffing levels were generally in accordance with the planned numbers. Where staffing levels were not in accordance with the planned staffing levels the spread sheet recorded the reason; for example, it was a rostered change as the staffing needs of the NNU were greater or less than the planned numbers of staff identified on the planning spread sheet. Staff told us the service had taken steps to mitigate risk; this included the use of bank staff and on-call cover. Staff told us that occasionally NNU nurses were deployed to provide support across children and young people's services at times of staff shortages.
- Both NNU, the paediatric assessment unit (PAU), and the children's ward used a daily bed occupancy flow chart to estimate the number of nursing staff and skill mix required to maintain safe staffing numbers on wards. The NNU had: two ICU cots with a staff to child ratio of 1:1: 3 HDU cots with a staff to child ratio of 1:2: 16 SCBU cots with a staff ratio of 1:4. This was in accordance with the British association of perinatal medicine (BAPM), 'service standards for hospitals providing neonatal care, 2010' guidelines.
- Nursing staffing appeared on the service's risk register. The children and young people's 'annual clinical governance report, May 2015' recorded that the children's ward had one WTE band 7 vacancy, and 19 band 5 vacancies. The ward 24 matron told us that at the time of our inspection the vacancy rate was 24% for band 5 nurses, with all other nursing staff bands being filled. We saw that the service was actively recruiting for band 5 nurses by advertising the vacancies both internally to staff who work at the trust and externally to national and international candidates. The service had successfully recruited a number of nurses from the Philippines who were awaiting visas. The trust were also considering at a policy of 'grow your own' nurse staffing, by offering qualified nurse training sponsorship to senior health care assistants and offering paediatric training to nurses from adult healthcare backgrounds.
- The children and young people's 'annual clinical governance report, May 2015' reported, "safe and effective quality of care provided continued despite the long standing nursing vacancies, with no noticeable increase in the number or severity of incidents reported, no increase in the number of staff leaving or staff sickness."

- The trust employed one WTE play specialists and three WTE play assistants. Play specialists were an integral part of the ward and department teams. Play specialists work with children to make the hospital environment welcoming and fun. They answer questions children may have about what will happen on the ward and reassure children. The play specialist team were all NVQ 3 qualified in specialism.
- Nursing staff on the children's ward told us they had a twice daily hand over; staff were not to be disturbed during hand overs as this was classed as protected time. Nursing handovers occurred at each change of shift. On the paediatric wards the nurse in charge who had the overall co-ordinating role, received a detailed handover from their counterpart. We viewed a children's ward handover sheet and saw that staffing for the shift was discussed, as well as any high risk patients or potential issues.

**Medical staffing**

- All children were seen by a consultant within 14 hours of admission to the ward.
- There were two consultants on call, one each for the paediatric and neonatal between 09.00am to 5.00pm, Monday to Friday. From 5.00pm to 09.00am there was an on-call consultant that covered both the NNU and the children's ward. There was at least one consultant in residence from 5.00pm to 10.00pm, Monday to Friday. There were usually two available consultants from Monday to Thursday. At weekends and Bank Holidays there was one consultant on site from 09.00am to at least 2.00pm, if there was not a clinical need for the consultant to remain on site, the consultant returned at 9.00pm to supervise the handover and review new admissions. There were consultant led ward rounds in every 24 hour period Monday to Friday and two ward rounds at weekends. The matron told us a consultant lived very close to the hospital and would come in out of hours in an emergency.
- Wexham Park Hospital had a 10 registrars, middle grades (ST4-ST8), rota from Monday to Friday between 9.00am to 5.00pm, with a registrar being allocated to the children's ward, another registrar was allocated to NNU and PAU. An additional middle grade doctor worked on PAU between 2.00pm to 10.00pm, Monday to Thursday: From 5.00pm to 10.00pm there was one middle grade doctor or consultant covering the ward and NNU. From 10.00am to 9.00pm there was one middle grade doctor on site. The trust added an additional middle grade between twilight until 01:00am, seven days a week to provide cover for the service's the busiest hours in the evening.
- The medical skill mix showed there were more junior doctors and fewer consultants when compared with the England average. This was made up of 26% consultants, compared to the England average or 35%; 8% middle career, compared to the England average of 7%; 52% registrars, compared to the England average of 51%; and 14% junior doctors, compared to the England average of 7%.
- The trust were meeting BAPM 2014 guidelines for medical staffing on the NNU. A neonatal consultant was on-call at all times; none of the staff reported any difficulties or delays in receiving attention from a consultant. Nurses told us that when they were concerned about a patient, they were encouraged to call the consultant.
- Junior doctors across Children and young people's services reported that they had very good training and support from their senior consultants.
- Consultants undertook ward rounds daily, including at weekends. There were two handover sessions per day for the medical teams. A consultant was present at all handovers.

**Major incident awareness and training**

- Staff were aware of the trust's business continuity policy, senior staff understood their roles and responsibilities within a major incident.
- The trust had conducted a desk top exercise for a major incident in 2013/14. This had resulted in an action plan, including the service having up to date mobile telephone contact details for all consultants; and community nurses being allocated to assist on the wards.
- The trust had a policy for capacity pressures in winter months, this included keeping the PAU open overnight as an escalation area.

# Services for children and young people

## Are services for children and young people effective?

Good

Overall we rated services for children and young people at Wexham Park Hospital 'Good' for 'Effective' because:

Children and young people had good outcomes because they received effective care and treatment that met their needs. Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Outcomes for people who used services were positive, consistent and met expectations.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff, and used to improve care and treatment and children and young people's outcomes. Children were cared for by a multidisciplinary team of dedicated and skilled staff. Staff felt supported and had access to training. Consultant support and presence was provided over seven days.

**Evidence-based care and treatment**

- Children and young people's services had a band 7 nurse who was a practice development nurse responsible for ensuring that practice was based on national best practice guidance.
- Children and young people's services regularly reviewed the effectiveness of care and treatment through local audit and national audits. We viewed the paediatrics and neonatal annual clinical audit report, April 2014 to April 2015. During this period children and young people's services had registered 13 new audits. These included: a NICE guidance re-audit on paediatric head injury management (CA176); and a NICE guidance audit on the management of febrile illness in children under five years of age (CG160).
- We viewed the trust's results for the national 'epilepsy 12 audit', November 2014. The findings of the audit resulted in an action plan for the trust to provide separate dedicated areas for teenagers away from younger children; and identified the need for a separate epilepsy nurse working in conjunction with Oxford University NHS Foundation Trust. Work was in progress to provide an epilepsy nurse; and young people had been provided with separate male and female areas on the children's ward.
- The trust had undertaken the British Thoracic Society, '4-BTS paediatric asthma audit', June 2014. This had resulted in a recommendation of a paediatric discharge plan. We saw that the service had produced guidance for staff on discharge planning.
- The trust had also undertaken Royal College of Emergency Medicines 'sepsis 6 audit' in 2014. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The service had produced an action plan in response to the audit. These included: altering the PAU documentation, as well as the triage nurse documentation to ensure patients' documents were correct; ensuring the admission book was filled in with patients who had triggered sepsis 6; and ensuring the first dose of antibiotics administered to a patient was timed and dated. The trust had arranged a re-audit of sepsis 6 in December 2015, to ensure the action plan was being implemented.
- The Trust was working towards level 2 UNICEF Baby Friendly accreditation. The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). The trust monitored the implementation of clinical guidance via a spread sheet. For example, the trust were 95.7% compliant with the core measures for NICE CSGCYP guidance 'improving outcome with children and young people with cancer.' The trust were meeting the needs of children with atopic eczema, in accordance with NICE guidance. However, the trust were not fully compliant with the guidance as there was no specialist paediatric dermatology nurse in post.

- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. Staff we spoke to knew how to access them when necessary.
- There were 146 clinical guidelines for both neonatal and paediatric care available on the trust's intranet. The service had a departmental guidelines review process that was led by a consultant. The consultant had a list of clinical guideline review dates. The trust also had a range of clinical guidelines and pathways that were shared with the services clinical networks, including the Thames Valley cancer network, the Thames Valley and Wessex neonatal network and the Buckinghamshire CCG children's advisory group. Clinical guidelines were reviewed and updated in 2015, with out of date guidelines being archived. The service was working with its networks to develop regional guideline for common paediatric problems.

**Pain relief**

- The trust was found about the same as other trusts in question 11 of the children and young people survey 2014, "do you think the hospital staff did everything they could to help your pain."
- Children and young people's services had a pain relief link nurse who had completed a level 4 module in pain management. Pain was assessed and managed appropriately. We observed age-specific tools in use in the NNU and the appropriate national guidance was followed. Patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain.
- Appropriate equipment was available including equipment for patient-controlled analgesia (PCA). The lead anaesthetist for children was involved with the children's pain strategy.
- The play specialist team were available in each ward and department, and provided distraction technique therapy for children undergoing a variety of procedures. Play specialists described numerous distraction therapies and techniques they used to help reduce patients' pain and distract them from painful procedures.
- Parents we asked confirmed that staff ensured their children were not in pain.

**Nutrition and hydration**

- The trust was found about the same as other trusts in questions 24 of the Children and young people survey 2014, "did your child like the hospital food."
- The ward areas had a protected mealtime's policy, which meant that children and young people could eat without being disturbed, except for parents and siblings. We saw that this was observed by staff on the ward.
- Children's likes and dislikes regarding food were identified and recorded as part of their nursing assessment on admission. Children's and young people's wards used a nationally recognised screening tool for the assessment of malnutrition in paediatrics to determine if patients were at risk of malnutrition. We noted that there were plans of care for any children at risk, with input from speciality teams as required. Children and babies were frequently weighed, and there were records relating to their fluid, nutritional intake and output. The records we reviewed during our inspection showed that fluid or dietary intake was monitored and recorded where required.
- Children and young people were able to choose what they wanted to eat from a menu. Staff told us, if children didn't want what was on the menu they could have an alternative by request. Support was available from dieticians for specialist advice and support with special diets. Staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- There were adequate facilities for the management of bottle-feeding.

**Patient outcomes**

- The service took part in all the national clinical audits that they were eligible for. For example, the trust took part in the NNAP. The annual report showed that, for the period of January to June 2015, the trust was achieving either the national average or better than the national average in the NNAP audit. For example, the trust achieved the standard that all (100%) of babies of less than 28 weeks gestation have their temperature taken within one hour of delivery: mothers of premature babies received antenatal steroids (85% against a target of 85%): babies that received mother's milk when discharged from a neonatal unit (59% against a target of 59%); other key standards were babies that received

retinopathy of prematurity screening (96% against a target of 100%); babies received a documented consultation with parents within 24 hours of admission to the neo-natal unit (100% against a target of 100%).

- Readmission rates were below 10% between October 2014 and July 2015. For 2014/15 readmission rates for medical was 8.6% and surgical was 4.6%, making a combined readmission rate of 7.4%. The service had comprehensive discharge planning to reduce the likelihood of patients being readmitted. The matron told us that readmission rates were sometimes skewed by children with bronchiolitis being readmitted.
- The average length of stay rate was an average of two days, between October 2014 and July 2015. The service provided in patient care for children up to the age of 16. Staff told us 16-17 year olds would be given the choice of admission to an adult or a paediatric area according to bed availability, providing they did not display behaviour unsuitable for a children's ward environment. Staff said this would always be decided in consultation with the young person and their family.
- Staff told us the service had very few child deaths. Children's and young people's services did not have a specific end of life care policy for children's services. However, the service had processes in place to undertake mortality and morbidity case reviews should this be required as part of the service's governance arrangements.

**Competent staff**

- Information we saw on the wards and in the departments showed that most staff had received an appraisal in the last 12 months. Staff we spoke with during the inspection confirmed that they had received an annual appraisal. All of the nursing staff we spoke to told us they felt well supported by their ward teams and the senior nursing and managerial staff.
- All senior nursing staff had attended or had dates to attend European paediatric life support (EPLS) or advanced paediatric life support (APLS) training. This would ensure there was an accredited nurse on duty during every shift.
- The percentage of staff qualified in speciality (QIS) on the NNU was 56.9% according to the children and young people's 'annual clinical governance report, May 2015'; this was in comparison with the national benchmark of 70%. However, two members of the NNU team were due to commence QIS training in September 2015.
- The children and young people's senior medical secretary had worked at the hospital for 12 years and had received a trust wide customer service award for "excellence" in customer service.
- Junior medical staff reported good access to teaching opportunities and said that they were encouraged to attend education events. The junior doctors we spoke with told us they received good educational supervision' and said that the consultant staff took an active interest in their teaching.
- We saw that staff had the right qualifications to do their jobs and had access to further development. For example, in December 2014 the trust introduced a system of giving junior doctors feedback from monthly clinical governance meetings. The feedback was directly targeted at areas of learning and improvement for junior doctors. In January 2015 the trust had further introduced junior doctors meetings. The aims of the meetings were to enable junior doctors to feedback on their department, as well as gaining skills in clinical governance.
- The trust had a practice development nurse and a practice educator who had developed a comprehensive preceptorship programme for newly qualified nurses. This was a structured period of transition for the newly qualified nurses when they started their employment at the hospital. We viewed comments from newly qualified nurses' evaluations of their learning, and found these to be consistently positive.
- Nursing staff had annual study days covering clinical scenarios and update sessions. Nursing staff told us the practice development nurse or matrons regularly assessed their competence in medicines management and drug insertion. All staff trained in chemotherapy giving had completed updates in February 2015.
- Nursing staff and administrators annual appraisal rates were 83% in September 2014, but this had fallen to 53% in May 2015. Staff told us this was due to a new system

being adopted from Frimley NHS Foundation trust and training in the new system being delayed. Staff told us work was in progress to ensure staff received annual appraisals.

- The medical staff we spoke to all confirmed that they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and good training opportunities. Junior doctors had a weekly teaching programme that was mapped to the royal college of paediatrics and child health (RCPCH) curriculum.

**Multidisciplinary working**

- There was strong evidence of multi-disciplinary team working in all departments, within and outside services. There were regular weekly multi-disciplinary team meetings. We also saw evidence of engagement with external agencies such as social services and networking with other children's services to share specialist expertise. For example, information on the attendance of children who were subject to a child protection plan, child in need plan, or children looked after by the local authority was routinely sent to the allocated social worker.
- Neonates, children and young people had children access to 1.8 WTE paediatric dieticians the dieticians did not cover on call for each other, but had a system where only one went on leave at a time. The paediatric physiotherapy team covered both inpatients and outpatients consisted of a band 7 physiotherapists for 20 hours week, band 6 physiotherapists for 52.5 WTE hours and a rotational band 5 physiotherapists for 37.5 hours. Changes to the physiotherapy were planned in October 2015 with a band 6 moving to Frimley Park Hospital.
- Children and young people's services were within the hospitals on-call service and weekend cover included orthopaedics.
- Medical and nursing staff worked closely with the paediatric psychology team for children with complex needs throughout the referral, discharge and transition processes. The paediatric psychology team also provided eight sessions per week: Four sessions at band 8b, two sessions to paediatric diabetes and two for oncology: Four sessions at band 7 for general paediatrics. One session was provided by Oxford university hospital. The chief of service was seeking funding to keep the extra session. From October 2015 the service was due to have between three and four sessions of trainee clinical psychology time to support the service.
- There was support from a paediatric speech a language therapist, (SALT), one SALT worked two days a week 8.30am to 4.30pm Wednesday and Thursday on the children's ward, NNU, and outpatients. A further SALT worked two full days, Thursday and Friday, for cleft lip and palate patients.
- The trust employed a paediatric liaison health visitor who worked closely with the children's ward staff and the NNU to ensure care was transferred effectively to community services. The health visitor attended daily doctors' handovers on the children's ward to identify support families or children may need. The health visitor also attended the NNU on a weekly basis to: identify any needs families may have; to offer families' advice on the Health Child Programme (HCP); and to signpost families to community based services.
- There were qualified play specialists available on the paediatric assessment unit (PAU) and the children's ward seven days a week.
- We noted that young people up until the age of 16 were cared for within the service. Staff told us that young people over the age of 16 would be consulted about whether to remain on a children's ward or whether an adult ward would be more suitable.
- The trust had clear pathways and protocols in place in regards to operating theatres; these were based upon the world health organisation (WHO) protocols. Almost all operating at Wexham Park Hospital was carried out as day case admissions. Children operated on outside the dedicated paediatric lists were placed at the beginning of the operating list. There were dedicated paediatric outpatient clinics for: general surgery; orthopaedic surgery; and ear nose and throat (ENT). The WHO checklist was audited on a monthly basis. We viewed the audits for July and August 2015 and saw that there was 80% compliance with the checklist in both months. There were no themes in the area of non-compliance, and learning from non-compliance had been addressed.

# Services for children and young people

- There were no separate paediatric surgery emergency rotas. All paediatric emergency admissions were managed by the on-call consultant in the relevant specialty, in close co-operation with the on-call consultant paediatrician. All paediatric emergencies were admitted to the paediatric ward at Wexham Park hospital. There was a dedicated paediatric emergency department adjacent to the main emergency department (ED). Emergency ear, nose, and throat (ENT) cover at consultant level was shared between Wexham Park and Reading hospitals.
- The paediatric physiotherapy team consisted of a 20 hours WTE band 7, band 6 covering 52.5 hours, and a rotational band 5 who worked 37.5 hours. This covered in and out patients.
- Children and young people's service was within the on-call service and weekend cover included orthopaedics. The physiotherapy service was scheduled to change in November and December 2015 with the departure of a band 6 to Frimley Park hospital and the accumulation of spare hours within the physiotherapy team.
- The Paediatric Psychology team offered four sessions a week at band 8b, these were divided into two sessions for paediatric diabetes and two for oncology. There were also four sessions at band 7 for general paediatrics. From October 2015 the service was due to have between three and four sessions of trainee clinical psychologist time to support the service.
- Paediatric speech and language therapy, (SALT), worked two days a week, 8.30am to 4.30pm Wednesday and Thursday, covering ward 24 and outpatients. There was also a SALT working two full days, Thursday and Friday, for children and young people with cleft lip and palate needs.
- The service had a paediatric haematology oncology service. This was a level 2 paediatric oncology shared care service (POSCU) with the Thames Valley cancer network. The service participated in the national peer review process. The trust achieved 91.7% compliance with peer review measures.
- The PAU worked closely with staff from the paediatric ED having shared guidelines, and the consultant from the ED attending afternoon handovers. Children under the age of one year could be fast tracked from the ED to the PAU.

**Seven-day services**

- The children's ward, the PAU, and the NNU operated a 24-hour service.
- The middle grade doctors' rota was altered in September 2015 to increase the number of middle grades available at peak activity times and at night. There was no increase in the number of doctors on the rota. The senior permanent middle grade doctors were doing twilight shifts until 1.00am. This allowed patient flow to continue through the night handover and support the night registrar until the early hours. The senior permanent middle grades were doing additional short six hour weekend shifts 3.00pm to 9.00pm to help cover peak activity times. Twilight shifts 12.00pm to 1.00 had been introduced in the registrars rota for Friday, Saturday and Sunday. A third registrar was on site 5.00pm to 10.00pm on Friday evening.
- Two consultants were appointed in August 2015 with an interest in acute care. Their role was to develop and support pathways of care with both CCGs and the Emergency Department (ED). Consultant cover of the assessment unit Monday to Friday was 9.00am to 5.00pm had been increased. The number of consultants on site Monday to Thursday 5.00 pm to 10.00pm had been increased. There was always one, usually two and sometimes three dependent upon staff annual leave. On Saturday and Sunday mornings two consultants did a ward round on the paediatric and neonatal unit. This facilitated faster discharges and forward rounds to be completed earlier. This was a recent introduction it was expected that as a result the unit will be then more able to manage the acute referrals during the peak activity times later in the day as the routine work would be completed earlier.
- During 2015 the consultant working pattern was modified to see children admitted to the unit within 14 hours of arriving at the hospital. The number of consultants on site between 5.00pm to 10.00pm Monday to Friday was increased. The service had three

consultant led handovers in any 24 hour period and this was well established. As well as discussing the in patients, new admissions were also reviewed by the consultant at the 10.00pm handover.

- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. There were pharmacists on call out of hours.
- Physiotherapy services were available seven days a week. Out-of-hours support was available through an on-call system.

**Access to information**

- Senior staff were aware of the trust's Caldicott Guardian, this is an appointment whereby the holder has responsibility to ensure the protection of patient confidentiality. This meant patients could be sure that their confidential records would only be shared if appropriate to do so.
- GP's were informed of patients discharge on the day of discharge. Care summaries were sent to a patient's GP on discharge to ensure continuity of care within the community. GP's could telephone consultants and registrars for advice following discharge.
- Information staff needed to deliver effective care and treatment was available to staff in a timely and accessible way. For example, patients medical records were stored in lockable trolleys in the doctors' office on the wards. Nursing notes were stored in a lockable filing cabinet on the ward.
- The service used the 'personal child health record' (PCHR), referred to as the "red book", and encouraged parents to bring these to hospital if their child attended an appointment or received treatment.

**Consent**

- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff we spoke with were aware of Gillick competence, this is a decision whether a child, 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with a child and encourage them to involve their parents where appropriate; but would respect the rights of a child deemed to be competent to make a decision about their care or treatment.
- We observed how staff talked and explained procedures to children in a way they could understand. Services for children and young people at the hospital were caring. We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a nurse explaining in accessible language what she was doing, why she was doing it, and what she would do next to a five year old who had been admitted to ward the children's ward.
- All the parents we spoke with told us they felt very involved in their child's care. We saw that staff spent time with children, young people and their parents to ensure they understood their care and treatment, and were supported throughout their time in hospital whether as an inpatient or an outpatient.

## Are services for children and young people caring?

Good

Overall we rated services for children and young people at Wexham Park Hospital 'Good' for 'Caring' because:

Children and young people and their parent were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from children, young people and parents was positive about the way staff treated patients. Patients and parents were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Staff helped children and young people and those close to them to cope emotionally with their care and treatment. We observed many examples of compassion and kindness shown by staff across all the ward areas and departments.

Children and young people were involved in making decisions. Staff spent time talking to children, young people and parents. Children, young people and parents understood their care, treatment and condition. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs as and when required. Children and

young people's privacy and confidentiality was respected at all times. Children and young people were supported throughout their time in hospital whether as an outpatient or inpatient.

**Compassionate care**

- The trust had implemented the friends and family (FFT) survey, an average of 98% of children, young people and parents who responded to the survey would recommend the service between April and August 2015, with an average response rate of 22%.
- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach. A young person on the children's ward told us, "They've been nice. The nurses and doctors are kind. They gave me a TV to watch and a DVD."
- Staff told us that the hospital had access to interpreters if required and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection.
- All of the parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child. For example, one parent told us, "They've been amazing. They've told me exactly what they intend to do. We haven't experienced any waits. The GP rang ahead and a doctor was waiting when we arrived."
- We saw that children and young people's privacy and dignity was respected by staff drawing curtains when providing intimate care or treatment. Play specialists worked with nursing staff on the PAU and the children's ward to ensure that children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.

**Understanding and involvement of patients and those close to them**

- The trust was found about the same as other trusts in section C2 of the children and young people survey 2014. Questions included, "did the hospital tell you what was going to happen to your child while they were in hospital;" and, "did members of staff treating your child give you information about their care and treatment in a way that you could understand."
- All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. However, one parent told us they hadn't been informed by staff of facilities that were available for young people on the children's ward, including a conservatory room and DVD loans.
- There were age appropriate leaflets and booklets for children and young people that explained the different procedures they could have, as well as their medical or surgical condition.
- Staff encouraged parental involvement in ward rounds. All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. We observed staff communicating with children, young people and parents to ensure they understood their care and treatment. Parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so.
- The children's ward provided a timetable of monthly activities for children and young people. This included entertainers including a magician and a balloon maker. Children were provided with a Christmas stocking at Christmas and Easter eggs at Easter. Staff assured us that they were aware of the need to be culturally sensitive during religious holidays.

**Emotional support**

- It was evident from our discussions with staff that they were very aware of the need for emotional support to help children and families cope with their care and treatment. Parents and relatives we spoke with confirmed this during our discussions with them.
- The trust's play specialist team worked alongside nursing and medical staff to provide support to children and young people. Staff were aware of how anxiety can

impact the welfare of the child and made provision, where needed, to manage this. For example, play specialists offered support to children who were undergoing surgery to alleviate their anxiety.

- Parents we spoke with told us they felt confident in leaving the ward and leaving their children in the care of staff on the ward.
- Children and young people who were experiencing mental or emotional distress had access to child psychologists.
- Children and young people who had received care or treatment from the service had access to the trust's counselling team, made up of British association of psychotherapy (BACP) accredited counsellors and therapists.
- Staff told us the hospital Chaplaincy would offer support for parents and others close to a child who had received bad news. Nursing staff told us they had received training in breaking bad news.

## Are services for children and young people responsive?

Good

Overall we rated services for children and young people at Wexham Park Hospital 'Good' for 'Responsive' because:

Children and young people's services were planned and delivered in a way that met the needs of children, young people and parents. The needs of different children and young people were taken into account when planning and delivering services.

Children and young people's care and treatment was coordinated with other services and other providers. There were clear pathways for children and young people when accessing and being discharged from the service. Each ward and department catered for the needs of individual children. Complaints were managed in accordance with trust policy and lessons were learnt.

### Service planning and delivery to meet the needs of local people

- The hospital did not have dedicated paediatric operating theatres. There was a dedicated theatre for each specialty and a dedicated emergency theatre. For the dedicated paediatric lists there was a dedicated recovery bay for children. For all other lists the trust aimed to provide a dedicated recovery area for children but told us this was not always possible. However, the recovery bay was staffed by appropriately qualified nursing staff/ODPs. Staff on the children and young people's wards as well as surgery staff told us children were reunited with their families in a timely way following an operation and would not be left for lengthy periods unsupervised in a recovery bay.
- The needs of young people were met by two dedicated young people's beds in a separate area on ward 24 until the age of 16. Staff told us young people over the age of 16 would be consulted about whether they would prefer to be treated on an adult or children's ward. This ensured young people received flexibility, choice and continuity of care.
- The children's ward offered placements to nursing students and was using the 'PAN London' practice assessment for nursing students. They had relationships with link lecturers at a number of universities. The matron told us offering nursing students practice placements was an aspect of staff planning, as students might wish to take up employment opportunities with the trust.
- Staff said they had a good relationship with child and adolescent mental health services (CAMHS). The matron on The children's ward said CAMHS were very responsive to requests for assessment and would attend the ward as soon as possible. Staff told sometimes they cared for young people with mental health needs overnight. If a young person with mental health needs was cared for on the children's ward an agency provided a registered mental health nurse (RMN), who was familiar with the ward, to work one to one with the child or young person and monitor their wellbeing.
- The service worked closely with community children and young people's services, who had an office based near the children's ward. Staff told us this made community services very accessible.

### Access and flow

- The children's ward was closed to new admissions on one night during our inspection. We asked the trust for

information on closures to the children's ward. The trust informed us that the ward had been closed three times in the previous three months. Three children had been transferred to Frimley Park hospital as a result of the closures.

- There had been 6984 spells in hospital in the previous 12 months. 77% of these had been emergency admissions; 5% had been elective; and 18% had been day cases. The primary diagnosis, 17.1%, for children aged one and under was acute bronchitis. This was slightly above the England average16.3%. The primary diagnosis for children aged one to seventeen was viral infection, 10.9%. This was close to the England average of 10.3%.
- The total number of children admitted in the previous twelve months was 5,004 to the ward, (medical and surgical), with 2,522 being non- elective medical and 998 non-elective surgical admissions. There were 31 babies under 10 days old and 252 16 to 18 years old admissions. Readmission rates were below 10%. The readmission rate for medical was 8.6%; and for surgical was 4.6 %. This was a combined average of 7.4%.
- The PAU assessed children who were referred by their GP. The PAU saw 7,483 children and young people. The main referral source, 2224, were GP referrals; 2,625 were from the paediatric emergency department (ED) and 1124 by other emergency means. In December 2014, 852 children were seen in the PAU. Between 95.4 and 100% of these children were seen and decisions about their care and treatment were made within the four hour ED target.
- The PAU general surgical and orthopaedic consultant led outpatients clinics along with visiting consultants for: oncology, respiratory, cardiology, gastroenterology, neurology, general surgery, orthopaedics, nephrology, urology, cleft lip and palate, and genetics. The was an average two week waiting time for appointments.
- The length of stay rate was an average of two nights between October 2014 and July 2015.
- The children's ward had completed a 'quality audit of discharge summaries' between 18 July and 24 July 2015. During the course of the audit 36 children or young people were discharged from the ward. Learning from the audit was identified and an action plan was in place to address areas for improvement. In August 2015 94% of medical discharge summaries were completed within 24 hours of discharge.
- The NNU team discussed planned deliveries of babies with the anti-natal service and delivery suite on a daily basis.
- The neonatal quality committee report for September 2015 found the overall average occupancy level for NNU in the previous month was 73%. The optimum occupancy level was 70% according to BAPM guidelines. The children and young people's 'annual clinical governance report, May 2015, found that the NNU was 80% compliant with BAPM toolkit for neonatal occupancy levels. The nationally accepted level is 80%.
- Children could be admitted to the children's wards from the children's emergency department which was separate from the main emergency department.
- The service offered adolescent transitional clinics for diabetes, epilepsy and gastroenterology to try and make this move as easy as possible. The service had a transitions nurse to assist young people with transitions in their care and treatment.

**Meeting people's individual needs**

- Each ward and department catered for the needs of individual children. This included ensuring that there was enough space next to each bed or neonatal cot for a parent to visit.
- The children's ward had a conservatory that had been furnished and decorated for adolescents. There was also an outdoor seating area with a patio table and chairs young people or visiting families could use. Young people could watch DVD's in the conservatory, that also had a gaming console young people could use. The children's ward had a large play room for younger children and an outdoor play area this had toys available and a selection of children's books and DVD's. There was a stock of DVD players that could be loaned to children and young people as well as a stock of DVD's. The DVD's were stored in a lockable cupboard and stored according to British board of film censors classification to ensure children only had access to age appropriate DVD's.

# Services for children and young people

- The trust was found about the same as other trusts in question 39 of the children and young people survey 2014, “how would you rate the facilities for parents staying overnight.”
- The NNU had four parent bedrooms that had been fully refurbished in 2015. Parents could stay with their baby in the rooms in preparation for discharge or for compassionate reasons. The service had a breast pump room with dedicated breast feeding chairs available as well as a coffee room and full kitchen facilities. There were also shower facilities. Parents, children and young people had access to free Wi-Fi and access to TV/DVD player. Breast Milk fridges were available in each nursery where mothers' could label and store their milk. Donor breast milk was available from the John Radcliffe hospital, Oxford NHS Foundation Trust. Car Parking was free for parents throughout a baby's stay on the NNU. Headphones were provided to listen to parents; so that they could stay near their baby during ward rounds to encourage 24 hour parental presence.
- The children’s ward had overnight beds for one parent to stay next to their child. There was a parents room available that had television, coffee making facilities and a dining area. Parents had access to a fridge and microwave to store and reheat their own food. Parents could have a hospital meal upon request at a charge of three pounds. We saw a parent purchase a hospital meal during our visit. This meant parents could stay on the ward and share a meal with their child. Staff told us there was no charge for food for breastfeeding mothers. There were separate toilet and shower facilities for parents.
- All permanent open access patients received free parking including outpatients. There were three isolation single cubicles used for oncology children and their families that were equipped with a fridge in each room.
- The trust had a bedroom available where both parents could stay, for families with a child on the HDU.
- A consultant was available to answer a GP “hot line” for one hour at lunchtime weekdays for case discussions. This had resulted in a reduction in GP referrals.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child’s bed. There was parental accommodation for parents whose children had to stay in hospital for a long period of time.
- There were sufficient play areas on the wards. Staff we spoke with told us that the service could meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs. We observed good facilities for children with disabilities. For example, funds had been made available to improve the ward environment for disabled children. Staff had been allocated to look at the use of a toy library, and purchase specific images for children with autism or delayed development.
- Adolescents were offered a choice of single sex accommodation on admission, dependent upon their clinical needs. The HDU was due to be redeveloped, when two cubicles would be available for single sex accommodation with monitoring facilities.
- Staff we spoke with were aware of the process to access a telephone translation service or face-to-face translator.
- Translation services were available for parents and children. A play team was able to provide qualified play specialists and play assistants to children’s services seven days a week. The play team were informed of all planned admissions at handover, and were involved in multidisciplinary ward rounds, as necessary. Play specialists provided a seven day service.
- The décor of the children’s wards was dated. However, play specialists had purchased wall décor that was child themed. The children’s ward had a good range of play equipment for all ages which was kept to a good standard.
- The parents’ rooms provided a variety of written information about treatment and care for a range of conditions.
- Wexham Park hospital had a multi faith chapel. A prayer mat was available to parents with access to quiet room for religious observance.
- Support was available for children with learning disabilities or physical needs from the trust’s registered learning disability nurses, as required.
- Staff told us that children awaiting an appropriate mental health bed were cared for on the ward whilst awaiting CAMHS assessment. In the interim families were invited to stay with their children on the ward where appropriate. Staff told us an agency registered

mental health nurse (RMN) would be employed to provide care for children or young people with mental health needs. This was at considerable cost to the trust, which was being discussed with the clinical commissioning group (CCG).

- Information for parents on access to patient records was available in the NNU information rack at the ward entrance; and at the reception area of the children's ward. This explained patients' rights under the Data Protection Act 1998 and the Freedom of Information Act 2000.

### Learning from complaints and concerns

- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns "on the spot." Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. Parents we spoke with all said that they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was on display in the parents' room. Leaflets detailing how to make a complaint were freely available. We only saw leaflets in English. This meant non-English speakers would have to request information on how to make a complaint from staff. Staff told us information in all languages could be requested on the same day from the hospitals accessible communications team.
- We saw that complaints and concerns were discussed at the monthly senior nursing staff team meetings and departmental clinical governance meetings. Lessons that could be learned from complaints were discussed at the meetings and actions to improve care or services were implemented. Complaints were also reviewed in the children and young people's 'annual clinical governance report, May 2015.' Actions the service had taken in response to complaints were reported to the board via the report.

## Are services for children and young people well-led?

Good

Overall we rated services for children and young people at Wexham Park Hospital 'Good' for 'Well-Led' because:

The leadership, governance and culture promoted the delivery of high quality child-centred care. There was a clear statement of vision and values, driven by quality and safety, with defined objectives. Strategic objectives were supported by measurable outcomes that were cascaded through the children and young people's service and throughout the trust. Staff in all areas knew and understood the vision, values and strategic goals.

The trust board and other levels of governance within children and families services functioned effectively. Structures, processes and systems of accountability, including clinical governance were clearly set out, understood and effective. There was evidence of children, young people and their families being engaged with services. We saw a range of innovations which helped to provide a flexible and responsive service.

### Vision and strategy for this service

- The children and young people's service had a clear directorate strategy for 2015-16. This included: improving HDU capacity and facilities at Wexham Park hospital and achieving the new high dependency care for children recommendations; further development of local paediatric surgery and paediatric ophthalmology.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. We saw that a new staff appraisal system had been introduced. The system was linked to the trust's values.
- There was a clear local vision and values that had been developed with children and young people's staff to ensure that they aligned with they worked for. These values were, "best care, best people, best place, best time." The values were embedded and underpinned staff behaviours.
- Most of the staff we spoke with understood the vision and strategy for developing the service, and said that

they felt they were kept informed. Staff were also aware of the trust's vision and values. Staff told us the trust's vision and values were communicated on the trust's emails.

- The children and young people's 'annual clinical governance report, May 2015', clearly defined the operational, medical, and nursing plans for the next 12 months; there were also plans for clinical governance for the next 12 months.

**Governance, risk management and quality measurement**

- The children's ward had received a trust wide team of the year award due to their, "commitment to excellence."
- The children's ward and the NNU conducted monthly audits of 10 children and young people's nursing documentation. There were nurse in charge quality rounds three times a week on both ward 24 and the NNU. The lead nurse conducted a quality round weekly across the service.
- Both the children's ward and the NNU used a quality dashboard to monitor the quality of services provided. The dashboards were themed around the CQC key lines of enquiry (KLOE). This provided assurances by collecting information on the quality of care and outcomes. The dashboards were regularly monitored by the trust's 'quality committee' for themes and trends.
- There was a governance framework in place and responsibilities were clearly defined. We viewed an organisational flow chart; this gave staff guidance on the structure of the Wexham Park governance framework. This included monthly local staff meetings that fed into the paediatric risk management group, as well as weekly consultants meetings that provided consultants with the opportunity to meet and discuss issues.
- There were comprehensive governance meetings in place. These included bi-monthly 'paediatric clinical governance meetings' and 'paediatric directorate board meetings'. These meetings contained a number of standing agenda items including reported incidents, complaints and infection control. Staff attending the meetings fed back to children and young people's teams following these meetings to ensure teams were informed of the key issues. The meetings also fed into the wider divisional structure to ensure that trust-wide issues were picked up and any concerns from the children and young people's group were reported.
- A risk register was in place which identified the key concerns for the service. The risk register was linked to the trust's corporate objectives. There were 10 items on the register. The risk register was regularly reviewed and updated. We saw that actions the service had identified to mitigate risks, had been recorded on the risk register. The risk register had been reviewed in the children and young people's 'annual clinical governance report, May 2015'.

**Leadership of service**

- Services for children and young people were very well-led. The Chief of Service was appointed from Wexham Park hospital following acquisition. Departmental level leadership was effective. Consultants' roles and responsibilities were defined by the trust's job planning process. Staff on the children's ward were unanimous in telling us how the matron on the children's ward provided outstanding ward level leadership. The matron on ward 24 had received a trust leadership recognition award.
- There were governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that there were management systems in place that enabled learning and improved performance, and these were continuously reviewed. For example, low staff annual appraisal rates were identified on the NNUs dashboard. However, the quality committee were aware of this, as this was due to a new appraisal system being introduced, and an action plan was in place to address NNU staff appraisals.
- The trust's paediatric board held monthly meetings, which key representatives from the neonatal and children and young people's services met with trust representatives. However, the trust did not have a children's champion at board level.
- We saw that the local clinical leaders and managers encouraged co-operative, supportive relationships

among staff and teams, and compassion towards patients. Staff told us that local leaders were very visible and approachable. We observed the matrons advising staff on the wards on several occasions.

- Senior ward staff we spoke with said that they felt supported by senior management, and if they raised any concerns about the service, they would be listened to.

**Culture within the service**

- Staff told us that there was a very positive culture within teams, and that staff supported each other well. Staff told us the culture of the service was very focused on meeting the needs of children and young people who use the service. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children.
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their line manager. Staff we spoke with told us they felt able to raise any concerns.

**Public engagement**

- The NNU had taken part in the BLISS Picker parents' survey 2015; this was a national survey to assess parents' experiences of neonatal care. The NNU had an action plan in place in response to the survey. The NNU had met four of the seven survey recommendations and was taking action to address areas for improvement. These were: Parents to have a photo of a baby on admission, the NNU was offering all parents photos and some staff had been trained in photography: Parents to feel more involved in their baby's care and events, the NNU had introduced a parent diary for babies, parents and staff could enter information about activities or changes in care: To reduce the amount of conflicting advice parents were given, especially around feeding. A practice development nurse had completed training in feeding and staff had received training in the Baby Friendly Initiative in May 2015 and were attending monthly updates.
- There were FFT post boxes on all children's and young people's wards. This enabled parents, children, and young people to take part in FFT patient surveys in both inpatient and outpatient areas.
- Volunteers spoke to parents, children and young people for the 'patient experience tracker' this found that 90% of those interviewed would recommend ward 24 to others; 90% had faith and trust in the doctors, and felt listened to.
- The service had introduced, 'you said, we did,' boards to the ward areas. The boards informed children, young people and parents of actions the ward staff had taken to improve children and young people's experience of care and support on the wards.
- The children and young people's 'annual clinical report, May 2015' reported that the service was in the process of re-establishing a parent support group. However, staff we spoke with told us work had not commenced on this at the time of our inspection.
- There were annual parent's evenings that involved the multi-disciplinary teams for: cystic fibrosis and oncology. The children's diabetes team held an annual party for children, young people and parents. These provided opportunities to meet staff outside of their traditional hospital roles and share experiences with other families.

**Staff engagement**

- We saw a number of examples as to how children and young people's staff were kept informed by managers of service developments. Staff we spoke with said they felt engaged in services. For example, there was a series of 'paediatric nursing focus groups'. These provided opportunities for all nursing staff to hear about and be involved in service developments, as well as involving staff in learning from complaints and incidents.
- The trust had introduced a junior doctors' representative to the monthly paediatric clinical governance meeting to facilitate communication between the consultants, senior nurses, pharmacists and junior doctors; and to ensure junior doctors were engaged in clinical governance processes. Junior doctors also had their own monthly meeting in which they brought together learning from clinical governance meetings, morbidity and mortality meetings and safeguarding meetings.
- The staff survey found that NNU staff had reported finding it difficult due to being rotated with staff on the paediatric ward due to vacancy rates on the paediatric

ward having reached 45% at one stage in the previous 12 months. NNU staff had reported finding it difficult even when supported by a local induction and the professional development nurse. NNU staff told us the situation had eased due to new children and young people's ward staff having been recruited.

**Innovation, improvement and sustainability**

- We saw a range of innovations which helped to provide a flexible and responsive service. For example, there was a series of 'paediatric nursing focus groups'. These provided opportunities for all nursing staff to hear about and be involved in service developments, as well as involving staff in learning from complaints and incidents.
- The service had a 'what makes a good nurse of doctor' initiative. This engaged children and young people in informing the service of their expectations of staff. Responses to the initiative were displayed on the children's ward.

# End of life care

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

The End of Life Care (EOLC) team at Wexham Park Hospital were all employed by Berkshire Healthcare Foundation Trust (community services) with some posts funded by Frimley Health NHS Foundation Trust. The team consisted of a consultant, team leader, five palliative clinical nurse specialists (CNS), a practice educator and a secretary/ multidisciplinary team coordinator. The palliative team delivered palliative services to all clinical areas across the hospital and worked cohesively with all areas of the hospital involved in the care of patients who were on the EOLC plan.

The palliative care team provided a service seven days a week 8.30am to 4.30pm. On Saturdays and Sundays one CNS covered these hours, assisted by the community palliative CNS when required. Out of hours telephone support for palliative medicine was provided by a consultant on a rota system which was shared with East Berkshire and Buckinghamshire consultants. This covered two hospices, three hospitals and community teams.

We visited a variety of wards across the hospital including wards: 1A, 2, 3, 4, 5, 9, 16, 17, 18, 20, Eden and the intensive care unit (ICU). We also visited the patient affairs office, the Patient Advice and Liaison (PALS) office, bereavement office, Macmillan information centre, mortuary and hospital chapel. We reviewed the medical records of 11 patients at the end of life, seven drug charts and 17 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records. We observed care provided by medical and nursing staff on the wards. We spoke with two patients receiving EOLC and three of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results provided for patient surveys and other performance information held about the trust.

# End of life care

## Summary of findings

Overall we rated the EOLC services at Wexham Park Hospital as 'good' this was because:

- National guidance determines precisely what end of life care (EOLC) should look like for adults diagnosed with a life limiting condition in all care settings. EOLC is defined as a patient with less than 12 months to live no matter what the diagnosis.
- Overall we found the EOLC service provided by Wexham Park Hospital was good. The duty of the inspection was to determine if the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. The hospital provided mandatory EOLC training for staff which was attended, a current End of Life Care Policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
- Staff at Wexham Park hospital provided focused care for dying and deceased patients and their relatives. Facilities were provided for relatives of patients and patient's cultural, religious and spiritual needs were respected. Further supplies of syringe drivers were purchased to enable a dying patient to receive prompt, adequate and appropriate medication.
- The palliative care team had a high level of evidence based specialist knowledge. They worked well with the local hospice and other departments involved in providing EOLC. The team were well thought of throughout the hospital. They supported, trained and gave advice to other staff.
- There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. Through education and acknowledgement of national guidance the number of referrals to the palliative care team had increased since the last inspection and these referrals were seen and acted upon within 24 hours.
- At our last inspection of Wexham Park hospital we found the EOLC service to require improvement. This was because the service relied on the drive and vision of the EOLC team and not through any trust-wide strategy. EOLC did not appear to be a priority for the trust.
- Since the hospital's acquisition by Frimley Health National Health service (NHS) Foundation Trust the service had board representation and a dedicated clinical lead. This had resulted in a well led trust wide service that had a clear vision and strategy.

# End of life care

## Are end of life care services safe?

Good

We rated EOLC at Wrexham Park Hospital 'Good' for 'Safe' because:

- The issues highlighted in the previous report had been addressed and the service provided safe and effective care for patients who were recognised to be in the last 12 months of their live. The previous inspection highlighted there was an inadequate availability of syringe drivers for use for EOLC patients. The purchase of further supplies and the monitoring their location when in use had resulted in this situation being rectified.
- The trust provided us with the incidents relating to EOLC with evidence of learning achieved and the resulting changes in practice that took place. The trust used an electronic incident reporting system. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us they were encouraged to report incidents to enable learning as an organisation.
- There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained. The mortuary area was visibly clean. Staff in all departments could show appropriate hand hygiene and complied with the trusts policies and guidance on the use of personal protective equipment.
- We reviewed 11 medical records and care plans of EOLC patients. We observed the appropriate prescribing of medication for patients who were on the EOLC plan. The palliative care team documented changes in patient care needs and the management of their medications in the records.
- We saw the documentation used in the mortuary for recording patients' details and the patient affairs officer explained the systems in place to process death, burial and cremation certificates.
- The trust had a programme of mandatory training for all staff in line with the National Care of the dying Audit 2014 and we saw evidence and records of this training.

### Incidents

- The trust used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- There were no 'Never Events' relating to EOLC services. 'Never Events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- A total of 17 unique incidents had been logged since April 2015 which were attributed to EOLC. These incorporated incidents in the mortuary, reported by the palliative team and incidents relevant to EOLC reported throughout the hospital.
- Syringe drivers were the most common occurring key theme mentioned in seven incidents. Symptom control and staff training of syringe drivers in three incidents and the shortage and availability of syringe drivers was the principle incident. We were told by senior team and clinical staff this had been rectified with the purchase of further supplies and tighter control maintained by equipment services.
- Two incidents were recorded relating to the discharge of the EOLC patient. Additionally two incidents were recorded regarding incorrect documentation made in patient notes.
- Five incidents were recorded in the mortuary. Two referred to identification tags on the deceased and three incidents related to the breakdown of the exterior freezer. Incidents reported by the mortuary relating to deceased patients were discussed at monthly medicine and emergency department directorate clinical governance meetings. We observed in minutes of the meetings that action plans were developed where required.
- Staff told us that monthly morbidity and mortality meetings were in place. These were attended by medical and nursing staff. Action points were recorded at the end of each meeting and learning points discussed.
- An incident was reported in July 2015 stating that there was an insufficient number of staff on the ward which had put the existing staff under stress with the workload and had put patients safety at risk. The incident was investigated by the hospital. The reported lessons learned were to support staff during changes in unforeseen staffing shortages and ensure staffing levels met national guidance.

- The hospital complaints team worked to ensure that all complaints specific to EOLC were reviewed by the EOLC lead clinician. A representative from the complaints office attended the EOLC steering group meetings and provided a summary of complaints related to EOLC. If there were any recurrent themes these were addressed through changes in the education plan.
- The clinical governance team also provided a summary of clinical incidents related to EOLC governance and these were themed and addressed through education.
- Additionally, we were informed that there were regular clinical and business meetings within the palliative care department where clinical incidents and clinical pathways were discussed and actions identified.
- A responsibility of the bereavement office was to collect the deceased belongings and patients valuables from the wards and store appropriately. Money and jewellery were kept by the cash office and all other items were stored in bags in the bereavement office. We were told by the staff in the bereavement office that this made them feel vulnerable when working alone. The staff had highlighted this to their manager but were unable to provide evidence of reporting or action plans.
- Service users and their families were told when they were affected by something that had gone wrong. An apology was given and informed of actions taken. When we spoke to staff they were able to describe the rationale and process of duty of candour.

**Cleanliness, infection control and hygiene**

- We observed that all areas of the mortuary, including the viewing area were visibly clean. There were cleaning rotas in place.
- We saw ward and departmental staff caring for patients on the EOLC plan complying with the trusts policies and guidance on the use of personal protective equipment (PPE). We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- We saw on all wards visited that there was hand gel available at entrances and notices reminding staff and visitors to use them.

**Environment and equipment**

- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
- In our last report we highlighted that there was a shortage of available syringe drivers. We saw evidence that the hospital had obtained 30 new McKinley T34 syringe drivers to rectify this. These were maintained and regulated by the equipment services.

**Medicines**

- The hospital had a Management of Medicines Policy which was devised for Heatherwood and Wexham Park Hospitals NHS Foundation Trust in 2013 and was due for review in December 2015. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
- All registered nurses and medical staff received training about the safe use of medication for an EOLC patient and prescribing anticipatory medication. All patients on an EOLC plan were discharged from hospital with "Just In Case" medication which ensured that streamlined care was maintained.
- The trusts 'Care Plan for the Dying Patient' contained algorithms for symptom management for patients at the end of their live. The guidelines were comprehensively set out and presented in an easy to follow manner. These also contained guidelines for the use of McKinley T34 syringe drivers including set up and drug monographs. We spoke with medical and nursing staff who were able to show us the guidance which was available on the intranet and in all ward areas.
- Across the wards we reviewed seven medication charts for patients who were receiving EOLC. Five patients had been prescribed appropriate anticipatory medication and two patients were waiting to be reviewed by the medical team. The charts we observed showed that four medications had been prescribed but did not specify whether the diamorphine prescribed was for pain or dypsnoea. Statement 11 of NICE Quality Standards 2011 states that anticipatory medication should be prescribed separately for the five key symptoms (pain, agitation, nausea, respiratory excretions and dyspnoea) that may develop in the last hours or days of life. NICE advises that this should be standard practice to ensure that patients receive timely and appropriate care.
- The palliative care team had access to a Macmillan specialist palliative care pharmacist who was employed by the trust.

**Records**

# End of life care

- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger record book that contained the required information. We observed that the book was appropriately completed.
- On visiting the Patient Affairs Office we saw that systems were in place to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- Patients receiving care from the palliative team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Frontline staff on the wards then implemented the changes as required, such as applying a syringe driver or changing medication. We observed that the palliative team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes. This was then documented on the palliative team computer system. However, a patient we observed on ward 5 who had been assessed by the palliative care team had not been prescribed the five anticipatory medications recommendations by the medical team 24 hours later. NICE advises that these be prescribed to ensure that patients receive timely and appropriate care.
- Following the withdrawal of the Liverpool Care Pathway, the trust reviewed their Integrated Care Pathway for the Care of the Dying Patient and generated a care plan for the dying patient. Following the release of 'One chance to get it right' 2014 by the National Leadership Alliance for the Care of the Dying Person, the hospital worked with the hospice, chaplaincy, community and Healthwatch colleagues to generate the 'Care Plan for the Dying Patient'.
- The care plan was audited by the hospital in February 2015. Results of this audit showed that the care plan was not being uniformly completed, with a shortage of documentation recording communication with patients and their relatives and an involvement of chaplaincy services. An action plan and education programme was devised to rectify this.
- Across the wards we visited we reviewed 11 medical records and nursing notes which contained individualised end of life care plans. Four patients were on the 'Care Plan for the Dying Patient'. However, these four notes were inconsistently completed. One was completed by medical and not nursing staff; another completed by nursing and not medical staff and one was fully completed by both but not signed by a doctor.
- We observed in the notes there was documented evidence of on going support by the chaplaincy team, who placed a sticker in the notes to highlight their input.
- An EOLC patient on ward 18 was not supported by the 'Care Plan for the Dying Patient'. Staff explained to us that this was due to the relative's difficulty with accepting the situation. However, we observed that discussions with the family and the escalation plan had been well documented in the medical notes.
- We saw 17 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms and these were all completed as per national guidance.

**Safeguarding**

- Safeguarding was part of mandatory training and this was monitored by ward managers.
- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults. The relevant local authority and social services numbers were available for staff.

**Mandatory training**

- The National Care of the Dying Audit 2014 recommends that staff receive mandatory training in the care of the dying. The trust had a programme of mandatory training for all staff and we saw evidence and records of this training. All staff who had direct contact with patients received training for caring for patients and their relatives at the end of life. This specifically identified the need for staff to communicate well and practice care in line with national and local best guidance. This training was received at induction with an annual refresher.
- The palliative care team provided a specific session on EOLC for every induction programme. The palliative care team had a robust training programme for EOLC for all clinical staff. Nursing programmes they taught on included: induction training, preceptorship training and five EOLC study days for registered and non-registered staff. Medical staff training included mandatory training, annual events and an annual conference. The medical consultant (lead consultant for EOLC) also trained medical students from Southampton University during their surgical attachment.

- Safeguarding adults, Mental Capacity Act training and Deprivation of Liberty Safeguards (DOLS) was included on corporate induction of all clinical staff and was included in mandatory patient safety training which staff attended annually.
- DNACPR was an annual mandatory training session for clinical staff and was discussed at the induction of doctors.
- Training for the McKinley T34 syringe drivers was mandatory for permanent nursing staff and we were shown the records of attendance. E- learning was available for all staff and "train the trainer" sessions were available twice a year. An agency nurse told us that they did not receive specific syringe driver training from the hospital but was made aware of syringe drivers and EOLC at ward level.
- We were shown the mandatory training that the porters received which was stored electronically on a central file. The porters and managers we spoke with told us that their mandatory training was up to date and included adult and child safeguarding, fire, infection control, manual handling and mortuary training.
- The porters told us that they had received training to support the movement of patients to the mortuary after they had died. The training included the use of the mortuary out of hours to ensure that mortuary procedures in and out of hours were adhered to. The porters we spoke with were able to describe the process in a knowledgeable manner and were able to demonstrate that all patients were treated with dignity and respect.
- The patient affairs and bereavement officers also evidenced that they were up to date with their mandatory training.

**Assessing and responding to patient risk**

- A full review of the trust mortality review processes was undertaken during 2014-2015. As a result, a trust wide approach to mortality was initiated by the formation of the trust mortality review group. The group has led to a review of ward based early warning systems including the death certification process which have been tightened up to ensure that details are discussed with senior doctors.
- The officers in patient affairs support all bereaved families with the paperwork and processes for care after death. They ensure all GPs are notified within one working day of the death. All doctors when completing the medical certificate of cause of death complete an electronic letter to the GP.

**Nursing and medical staffing**

- The palliative care team consisted of a 0.9 WTE consultant, 1 x WTE team leader, 3.8 WTE palliative care clinical nurse specialists (CNS), 0.8 WTE palliative and EOLC practice educator and medical secretary/ administrative support. The duty rotas were arranged to ensure that Monday to Friday a minimum of three CNS were on duty. We were told that there were no vacancies in the palliative care team and the team leader actively managed the staffing to ensure safe service provision.
- There was one WTE occupational therapist who worked specifically with the palliative care team. The hospital also had three WTE occupational therapists who supported the discharge of an EOLC patient from hospital.
- We spoke to an agency nurse who told us they had worked on the same ward for the previous four months. They explained that this was a trust initiative to ensure quality and continuity of care. The nurse demonstrated their awareness of the process of caring for an EOLC patient and how they were able to access resources and support.
- During our inspection we asked ward managers about their staffing levels and whether they felt adequate staff were on the wards when caring for patients on an EOLC plan. Staff on Eden and ward 5 confirmed that retaining staff was a main concern but they were aware of the trust's efforts to manage the situation. Staff on ward 5 told us that sometimes they were unable to provide adequate specific EOLC to patients due to availability of staff and workload.
- Eden ward told us that in the last six months the process of handovers on the ward had improved. Every morning and evening there was a handover of confidential information and then a handover of non-confidential information took place by the patient's bedside. The process had been streamlined to ensure that staff were able to finish their shift promptly.

**Major incident awareness and training**

- There was trust wide major incident policy and training. An adverse weather policy was implemented to ensure there was palliative care cover in times of emergency.

# End of life care

## Are end of life care services effective?

Good

We rated EOLC at Wexham Park Hospital 'Good' for 'Effective' because:

- Since the acquisition by Frimley Health NHS Foundation Trust the hospital had corrected the organisational and clinical indicators highlighted in the National Care of the Dying Audit 2014. The hospital had trust board representation in place and there was access to information relating to death and dying. A patient satisfaction survey and bereavement survey had been developed for implementation by the end of 2015.
- The hospital had implemented standards as set by the National End of Life Care strategy 2008 published by the Department of Health, the National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) and 'One chance to get it right' 2014 by the National Leadership Alliance for the Care of the Dying Person. We saw the hospital had a regular audit programme.
- The palliative care team provided an EOLC service seven days a week between 8.30am and 4.30pm, with out of hours telephone support for palliative medicine provided by a consultant.
- The chapel was accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard.
- Alternative EOLC guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The 'Care Plan for the Dying Patient' had been generated. The hospital was piloting the assessment, management, best practice, engagement and recovery uncertain (AMBER) care bundle for patients who were recognised as being at risk of dying within one to two months.
- Patients on the 'Care Plan for the Dying Patient' were prescribed appropriate medication by medical staff. Patient's pain, nutrition and hydration were monitored in accordance with national guidelines. The palliative care team supported and provided evidence-based advice to health and social care professionals from other wards and departments.

### Evidence-based care and treatment

- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for EOLC, applicable to adults diagnosed with a life limiting condition. The National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) sets out what EOLC should look like for adults diagnosed with a life limiting condition. The 16 quality standards define best practice within this topic area and these were all being met by the hospital. Additionally the hospital had implemented NICE Quality Standards for Improving Supportive and Palliative Care for adults with the provision of a palliative team.
- We saw that a regular audit programme was embedded in the hospital. This included the National Care of the Dying Patient Audit 2015, local use of the 'Care Plan of the Dying Patient', the AMBER care bundle quality audit, 'do not attempt cardio-pulmonary resuscitation' (DNACPR) audit and compliance against care of the deceased adult policy. Also NICE standard 13 for end of life care and guideline 140 regarding opioids were audited.
- We saw evidence across the wards we visited that the palliative team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- The palliative care team supplied the wards with an EOLC resource folder which was known as the 'yellow box'. During our visits to the wards, staff were able to show us the resource folder and explain its contents. Additionally staff were able to demonstrate how they were able to access the EOLC information on the intranet and knew how to refer to the palliative care team.

### Pain relief

- The 'Care Plan for the Dying Patient' supports the effective management of pain in dying patients. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms.
- We reviewed seven patients' medical records and drug charts and saw that patients had regular assessments for pain and appropriate medication given frequently and as required.
- The trust undertook an audit against NICE standards for the initiation of opioids in 2015. No areas of concern were highlighted but indicated that the hospital needed

to prescribe anti-emetics and laxatives alongside opioids. The audit showed that EOLC drugs were used appropriately and in proportionate doses with no evidence of inappropriate or rapid dose escalation.

**Nutrition and hydration**

- Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool which identified patients who were at risk of poor nutrition, dehydration and who experienced swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording. The 11 care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietician. However, the dietician had seen a patient on ward 4 and had documented their assessment in the medical notes rather than the active 'Care Plan for the Dying Patient'. At patient assessed as being in the last days or hours of life and commenced on the 'Care Plan for the Dying Patient', only requires that record to be documented.
- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- We saw the checklist for mouth care for patients on the EOLC plan on the wards. All 11 care plans we observed were fully completed except for a patient on ward 17 who required oral hygiene. This was highlighted to staff by the inspector who observed that the patient received immediate attention.

**Patient outcomes**

- The integrated specialist palliative care hospital service collected data on their database. This service submits data annually to the National Council for Palliative Care, thus enabling them to benchmark local activity against national activity.
- Before the acquisition by Frimley Health NHS Foundation Trust the results of the National Care of the Dying audit 2014 showed the hospital achieved four of the seven organisational indicators and was below the England average for seven of the ten clinical indicators. The hospital achieved below the England average for the trust board representation for care of the dying, access to information relating to death and dying and formal feedback processes regarding capturing bereaved relatives views of care of delivery. However, since the acquisition the hospital had trust board representation in place and there was access to information relating to death and dying. At the time of inspection a new patient satisfaction survey and bereavement survey had been developed for implementation by the end of 2015.
- In 2014 there were 1149 deaths reported at Wexham Park hospital. Data for 2014/15 showed that 1254 new referrals to the palliative care team were received compared to 825 in 2013/14. In 2014/15 56.1% of referrals were for patients with a non-malignant disease and 57% (710) of contacts ended in death. The average length of care at the hospital was 10.4 days and 62.2% were discharged to home.
- The National End of Life Care Strategy 2008 published by the Department of Health, and NICE Quality Standard for adults (QS13) both defined EOLC as a patient with less than 12 months to live. The trusts End of Life Care Strategy 2010-2015 accommodated this recognising the differing trajectories of dying and the appropriate individualised care plans required. The palliative team worked collectively to implement the EOLC strategy.
- The trust piloted the AMBER care bundle which provided a systematic approach to managing and documenting the care of inpatients who were at risk of dying within one to two months. The pilot was trialled in wards 3 and 17 and will be audited in November 2015. We saw the AMBER care bundle in practice for a patient on ward 3 had been completed appropriately with all discussions recorded.
- Following the withdrawal of the Liverpool Care Pathway, the trust had reviewed their Integrated Care Pathway for the Care of the Dying Patient and generated a care plan for the dying patient. With the release of 'One chance to get it right' 2014 by the National Leadership Alliance for the Care of the Dying Person, the hospital worked with the hospice, chaplaincy, community and Healthwatch colleagues to generate the 'Care Plan for the Dying Patient'.

**Competent staff**

- We were shown evidence that the palliative care CNS team were all trained in specialist palliative care to at least degree level and some were pursuing masters level qualifications. The team leader had a post graduate

qualification in education. The team had completed advanced communication skills training, psychology level two training and participated in monthly clinical supervision with a clinical psychologist.

- The palliative medicine consultant demonstrated continued professional development in line with the requirements of revalidation. They were a named appraiser and clinical supervisor for foundation trainees.
- All the wards we visited had a link nurse who was an EOLC champion. We were told that the link nurse on Eden ward was attending a specific palliative care course and the link nurse on ward 9 expressed a request to do more training which was being encouraged by the trust. Some of the link nurses had also received 'train the trainer' training and were able to train and assess competences for staff on the wards. For example, the use of syringe drivers. There were monthly meetings for EOLC link nurses to disseminate their learning to ward staff. However, we were told that some nurses were unable to attend as there was no protected time allowance. We were told that the senior team were aware of this and was a point of discussion at the end of life steering group meeting minutes.
- Staff on Eden ward told us that the trust had funding for 45 places for training specific to their role, including EOLC, and staff were benefiting from this.
- We saw evidence that nursing staff, mortuary staff, porters, patient affairs and bereavement officers participated in annual appraisals and had personal development plans in place.
- The hospital had encouraged staff to improve their communication skills by funding them to attend the 'Sage and Thyme' training. The model trains all grades of staff how to listen and respond to patients and their families who are distressed or concerned. We were provided with evidence of attendance records and staff evaluation forms. Staff who attended the course told us that it was a valuable learning experience.

**Multidisciplinary working**

- The palliative care team had daily meetings and weekly multidisciplinary team meetings to discuss treatment plans for new and current patients. Recent deaths were also reflected upon. All members of the palliative team who were on duty, the head of cancer, and representatives from chaplaincy and pharmacy attended.
- The palliative care team worked closely with the pain team, acute oncology team, site specific cancer CNS and the non-cancer CNS to ensure seamless care was delivered to patients.
- The palliative care team, including the EOLC practice educator, supported the stroke and respiratory multidisciplinary teams to implement the AMBER care bundle. We were told that they were now supporting the elderly care wards to implement the AMBER care bundle.
- On ward 1A we observed a conversation between the EOLC practice educator with ward staff who was explaining the rationale for the prescribing and administration of additional anticipatory medication for an EOLC patient. We saw that there was good support provided for junior staff.
- Medical staff on ward 9 told us that the palliative care team were very supportive in assisting medical staff to have sensitive conversations with patients and their families regarding EOLC.
- All patients known to the palliative care team were referred to and seen by the chaplaincy team. In the period April 2014 to March 2015 they visited a total of 2,143 palliative care patients at Wexham Park Hospital. They were alerted by the computerised referral system and they also attended the daily palliative care meeting. To maintain continuity pastoral workers were allocated specific wards and we observed that they had regular presence on the wards.
- The chaplaincy team consisted of seven members: three chaplains and four Macmillan pastoral care workers. They told us that they possessed other skills and abilities besides chaplaincy. This included counselling, grief therapy and social work qualifications which assisted their role.
- The hospital had a Macmillan information centre located in the main reception. This was supported by the trust who employed the manager. They supported the hospital and community palliative teams and had strong links with the palliative care nurses. The office was open Monday to Friday and supported patients and relatives.
- The palliative care team supported the emergency department with a rapid response service. If a patient was on an end of life care plan and the community teams knew of the admission they would inform the

palliative care team to undertake a review. East Berkshire and South Buckinghamshire encouraged GPs to upload advance care plans to their electronic locality register.

- The hospital palliative care team had an integrated service specification for specialist palliative care across East Berkshire that included the acute trust, Thames Hospice and Berkshire Health Foundation Trust. The outcomes were aligned across the sectors to serve patients and their relatives well. The specialist palliative care medical consultant in the hospital worked in Thames Hospice two days a week and provided continuity of care for patients transferred across the service. The medical consultant attended the Buckinghamshire specialist palliative care provider board and the hospital team worked closely with the Ian Rennie Hospice at Home and with the two palliative medicine consultants who covered the Buckinghamshire hospitals and Florence Nightingale hospice.

**Seven-day services**

- The palliative care team provided a service seven days a week 8.30am to 4.30pm. On Saturdays and Sundays these hours were covered by one CNS and assisted by community palliative CNS services when required.
- Out of hours telephone support for palliative medicine was provided by a consultant on a rota system which was shared with East Berkshire and Buckinghamshire consultants. This covered two hospices, three hospitals and the community teams.
- Ward staff could either contact the palliative care team by telephone or use the 24 hour electronic referral system. This enabled patients to be seen and assessed within 24 hours of referral.
- The chapel was accessible 24 hours a day every day of the year. The chaplaincy team provided a 24 hour on call service for all faiths and were contactable via the switchboard. In the period April 2014 to March 2015 the chaplaincy team made 56 emergency responses out of hours.
- Viewings in the mortuary were possible out of hours but staff encouraged them to take place during working hours Monday to Friday 07.30am – 4.30pm. Out of these hours there was an on call mortuary attendant.

**Access to information**

- We were told that GPs were notified when a patient was started on the 'Care Plan for the Dying Patient' and were notified within one working day of the patient's death.
- Information leaflets for relatives were available for dying patients and those on the AMBER care bundle.
- The hospital had a blue butterfly sign which was attached to doors/ curtains when a patient had died to inform all staff that the deceased was present.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Medical staff we spoke with understood the DNACPR decision making process and described decisions with patients and families. They told us they provide clear explanations to ensure that the decision making was understood.
- While visiting ward areas we checked medical records and we viewed 17 DNACPR forms. We saw that all decisions were recorded on a standard form, signed by an appropriately senior clinician. With the exception of one patient on ward 20, all forms were kept in the front of the patients notes. Thirteen of the records had evidence that there had been discussion with the patient or relative.
- A trust wide audit was performed July 2015 which audited standards relating to the DNACPR form and documentation in the patient medical notes. The audit findings suggested that compliance had been sustained with providing clear documentation. Good compliance was evident regarding date of decision, reason and the record was clearly dated, timed and signed correctly. The audit however demonstrated that further action was still required to ensure compliance in other areas.
- None of the 17 records we observed had the review date section completed. We observed that a patient on ward 2 was admitted to hospital with a form signed by their GP and dated September 2013. There was no record of a review since this decision was made. The trust wide audit (2015) presented that 91.9% of forms had not stipulated a review date however; this standard did not require 100% compliance.
- The hospital had implemented the Unified DNACPR policy as Trust Policy TPP133b in May 2014. Section 11 of the policy states that the DNACPR decision is regarded as "indefinite unless a definite review date is specified" or "there are improvements in the person's condition".

# End of life care

- The Resuscitation Council (UK) guidelines 2015 confirm this but also state that "the decision should be reviewed whenever the patient is transferred from one healthcare setting to another". The guidelines also advise that a fixed review date is not recommended and should occur whenever circumstances change. There should be robust arrangements in place to ensure that they remain current and appropriate.
- We were told that DNACPR remains a high priority in teaching and focus remains on the documentation of the communication of the decisions with the patient and their relatives. A consultant for DNACPR had been appointed by the trust.
- The hospital had a consent policy in place which was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process, consent training and, use of information leaflets to describe the risks and benefits. The policy also includes consent for advanced decisions, and guidance for lasting power of attorneys and mental capacity.
- Staff on ward 4 explained to us the process and demonstrated a good understanding of completion of Deprivation of Liberty Safeguards (DOLS) for patients who were discharged using the fast track system as they had been assessed as lacking capacity to give consent.

## Are end of life care services caring?

Good

We rated EOLC at Wexham Park Hospital 'Good' for 'Caring' because:

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. We were told about and provided evidence of collaborative working across the teams to provide exceptional care for EOLC patients who wished to return home to die.
- We spoke with patients and relatives who were complimentary about the care they had received. Staff showed us thank you cards and letters they had received.
- On the wards we visited we observed compassionate and caring staff who provided dignified care to patients who were at the end of their lives.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support and patience from staff.
- Emotional support was provided by hospital staff and bereavement care was trust wide. There was an on call service with access to chaplaincy staff and other multi faith leaders who supported families in times of loss and grief.

### Compassionate care

- During our inspection we observed EOLC that was sensitive and caring by all staff. The palliative care multidisciplinary team provided the inspectors with copies of letters and cards from relatives thanking the team for their support and care. Comments included: "you undertook the role with compassion and common sense", "patient had a peaceful end" and "you made a difficult time a little bit more bearable".
- We observed the interaction between a member of palliative care team with an EOLC patient and their relative on ward 16. The nurse demonstrated that they were competent, knowledgeable, caring and had excellent communication skills.
- We were informed of two separate incidents of exceptional care provided for EOLC patients. The joint and collaborative work between the intensive care unit (ICU), palliative care team, discharge team, ambulance service, district nurse and GP enabled two patients to return home to die. Both of these visits were very successful and made a significant difference for the patients and their families.
- The Macmillan information centre told us of two examples where they had provided exceptional individualised care for EOLC patients and their families. One example involved the organisation of a marriage of a dying patient and the other involved counselling of a parent who was having difficulty coming to terms with the death of their relative.
- Staff we spoke with on all wards we visited said that EOLC was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives.
- We spoke with a relative of a patient on ward 9 who told us that staff were "very caring, explaining everything and treated the patient and family with respect". On the ward we saw three separate letters and cards from

relatives who were very complimentary about the care and treatment received for their loved ones who had died on the ward. Additionally prior to the inspection the inspection team had been notified by a relative of a patient who had died on ward 9 who complimented the staff and hospital for the "excellent" care they had received.

- A relative of an EOLC patient on ward 4 told us that their relative "couldn't have had better care even if they had paid for it". They told us that they had been given the choice for their relative to transfer to the hospice and they preferred for them to stay in hospital.
- A patient on ward 20 told us that they "were pleased with care received from the ward and the hospital, they were provided with individualised care and treated with respect".
- An EOLC patient on ward 17 stated they were very comfortable and looked after well but staff were slow to respond when they shouted. We observed that this patient's call buzzer was not within reach.
- We observed that mortuary staff and porters demonstrated good care of the deceased whilst protecting their dignity. We were shown thank you cards and letters the mortuary team had received from relatives.

**Understanding and involvement of patients and those close to them**

- We spoke with patients and their relatives. Staff providing EOLC were caring and professional. They told us they felt involved in their care and were given adequate information about their diagnosis and treatment. they felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with mouth care and personal care.

**Emotional support**

- Staff provided emotional support for EOLC patients. We observed occasions when this occurred.
- Bereavement care was trust wide. The relatives of all patients known to the palliative care team received a personalised written card and access for referral for bereavement support which was provided by the hospice. All GPs were informed within one working day of a patient's death so they could provide appropriate community centred bereavement support if required. The emergency department, ITU, paediatric and maternity provided bereavement councillors for deaths that had occurred within their departments.
- The chaplaincy service offered access to multi faith worship 24 hours a day. There was an on call service with access to chaplaincy staff and other multi faith leaders. The chapel was a space for patients and families to have quiet time.
- The chaplaincy team were involved in supporting families in times of loss and grief. They conducted monthly funeral services in relation to products of conception and non-viable foetuses, as well as private ceremonies in times of miscarriage, still-birth or neo-natal death. The Books of Baby Remembrance were held in the chapel with the pages turned daily by a chaplain.

## Are end of life care services responsive?

Good

We rated EOLC at Wexham Park Hospital 'Good' for 'responsive' because:

- The palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. This was demonstrated with their specialised advice and knowledge.
- All referrals for the palliative care team were accessible 24 hours a day. The team responded promptly to referrals to assess the patient and plan care. The team met their target of 100% for face to face assessment within 24 hours for all urgent referrals and within 48 hours for non-urgent.
- The previous inspection had judged this service to require improvement because of the lack of facilities for visitors of EOLC patients. At this inspection we found that staff supported relatives to stay with EOLC patients and assistance was given with parking permits.
- The previous inspection had judged this service to require improvement because the mortuary viewing area required refurbishment as it was unwelcoming for

relatives. At this inspection we found the hospital had a suitable viewing area of the mortuary and a chapel that both accommodated all faiths as well as no faith. Staff respected the cultural, religious and spiritual needs of patients. The palliative care team identified the cultural, religious and spiritual needs of patients and this was recorded this as part of the holistic assessment, and supported by the chaplaincy team.

- The chaplaincy team line managed the bereavement service. This had created a fluid cohesive service and offered an opportunity to develop and integrate bereavement support within the trust. The bereavement officers told us that they aimed to issue the death certificate on the day of death and had clear systems in place to support faiths requiring a funeral within 24 hours.
- The palliative care team were involved with all discharges for EOLC patients. They provided ward staff with a rapid discharge pathway which explained the appropriate action plan. This explained the actions to be performed and response time required. This depended on the patients preferred place of care and what area the patient lived in.

**Service planning and delivery to meet the needs of local people**

- During the inspection we observed that the palliative care team was embedded in all clinical areas of the hospital. Staff on the wards told us that the team were professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals, for example, therapists. Staff on Eden ward confirmed that the referral criteria was unambiguous and patients were seen within 24 hours if not sooner.
- We observed across the wards we visited that staff supported relatives to stay with EOLC patients. We were told and observed that when a patient was recognised as in the dying phase all wards would offer patients and their families side rooms dependant on availability and suitability. Five recliner chairs were available for relatives who wished to remain by the bedside.
- The hospital had provided concessions for visitors of patients who were end of life. Parking permits were provided to assist with the cost of parking.
- The EOLC lead told us that Eden ward have 3 complementary therapists for cancer and EOLC patients and 3 members of the pastoral care support team dedicated to them.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the mortuary attendant who would stay with the relatives in the waiting area during the viewing for as long as they required.
- The bereavement office was open Monday to Friday 09.00am to 5.00pm and employed one full time and two part time staff. Part of their responsibility was to collect property and valuables of patients and store appropriately. Their main focus was to advise relatives on the process around the death of a patient. The officer issued death, burial and cremation certificates and arranged viewing of the deceased with the mortuary.
- Guidance and support was offered immediately after death from the bereavement office. Contact numbers were provided to relatives within a statutory booklet. The bereavement officers told us they were aware of whom to signpost relatives to if they required additional support.
- The bereavement service was line managed by the chaplaincy team which had created a fluid cohesive service and offered an opportunity to develop and integrate bereavement support within the trust. The team had daily meetings and logged monthly team meetings for support, and planning the improvement of service.
- The bereavement officers told us that they aim to issue the death certificate on the day of death but were unable to provide any data to confirm this. They also told us that there were clear systems in place to support faiths that required a funeral within 24 hours.
- We were told that the maternity services had designed plans to refurbish their bereavement suite and 15 members of staff had already been trained to accommodate this. One member of staff on the maternity unit was trained in bereavement counselling.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 08.00 to 18.00 and employed one full time manager and two part time staff. The office was a spacious office located off the main corridor. It contained a separate seating area but this did not accommodate for confidential and private conversations.

# End of life care

### Meeting people's individual needs

- The mortuary had a viewing suite which was divided into a waiting and viewing room. The suite was visibly clean and provided facilities for relatives such as seating, tissues and information booklets about bereavement. The suite was neutral without religious symbols which allowed the suite to accommodate all religions.
- The mortuary was able to facilitate the transportation of bariatric patients with the availability of two specially designed beds. Additionally they had separate baskets for the transportation of babies.
- The hospital chapel was multi faith with areas that could be sectioned off to accommodate separate faiths. A Christian service was provided weekly on a Sunday by the chaplaincy team and there was a weekly Muslim service on a Friday which was led by the community. Other faiths had access to perform ceremonies in the chapel via the chaplaincy team. We were told that the team were able to perform services on the wards if required.
- In 2014 ablution facilities were built to accommodate ritual cleansing prior to prayer. This was jointly funded by the trust and the Muslim community and ensured that the faith needs of the community were met.
- We observed in the care plans and medical notes that staff respected the cultural, religious and spiritual needs of patients. It was identified by the palliative care team and recorded as part of the holistic assessment, which was supported by the chaplaincy team.
- The hospital had access to translation services which were provided by Slough Translation and Interpretation Services.

### Access and flow

- All referrals for the palliative care team were made via telephone or via the hospital computer system. Referrals via the computer were accessible 24 hours a day. Monday to Friday 8.30am to 4.30pm the palliative team administrator operated the office land line and out of hours the switchboard had access to a mobile telephone. The on call consultant for palliative care was available for telephone medical advice out of hours.
- The palliative care team had a target of 100% for face to face assessment within 24 hours for all urgent referrals and within 48 hours for non-urgent. Data provided by the palliative care team showed that in May 2015 the team received 127 referrals of which 126 were seen within 24 hours.
- Where the preferred place of death was known staff endeavoured to facilitate this. The palliative care team were involved with all discharges for EOLC patients. They completed all fast track applications to enable rapid discharge for patients on an EOLC plan. April 2014 to June 2015 there was a total of 147 applications.
- The use of fast track funding sometimes delayed the discharge of patients which was caused by where the patient lived. There was a lack of discharge pathways for patients who lived in South Buckinghamshire and there was a lack of capacity for patients who lived in East Berkshire. The average waiting days for South Buckinghamshire was 8.7 days and East Berkshire 14 days. The hospital acknowledged this on their risk register and individual cases were incident reported. For patients who lived in South Buckinghamshire the hospital had been working with commissioners to establish a joined up responsive service.
- We observed that there was good communication between the community and the hospital for patients whose preferred place of death was home. In 2014/2015 62.2% of palliative care team patients were discharged home compared to 40.8% in 2013/2014. .
- Ward staff were provided with a rapid discharge pathway which explained actions to be performed and response time depending on preferred place of care and what area the patient lived in.
- Staff on ward 5 explained to us the process regarding the discharge of a patient to their home with a syringe driver. This depended on where the patient lived. The hospital had clear guidance and processes in place regarding discharging a patient with a syringe driver who lived in the areas of South Buckinghamshire and East Berkshire.
- Medical staff on ward 9 informed us that they had collectively discussed the need to improve the content in the discharge summaries to ensure that GPs were better informed and thus able to provide a streamlined service.

### Learning from complaints and concerns

- Staff on the wards we visited explained to us the process should a query or concern be raised. The person would be directed to the PALS office. The PALS officer

explained to us they would liaise with the ward, nursing staff or consultant as appropriate and all efforts were then made to resolve issues as quickly as possible for patients and their relatives. The PALS officer told us that they managed on average 10 to 20 enquiries each day. On the day of our visit we observed that 10 enquiries had already been logged for that day and five had been resolved.

- During our visit we observed the PALS officer manage with three enquiries and these were all processed in a professional and efficient manner.

## Are end of life care services well-led?

Good

We rated EOLC at Wexham Park Hospital 'Good' for 'Well-led' because:

- The EOLC team at Wexham Park Hospital had a well led clear vision and strategy for the service. It was delivered in a timely, sensitive manner and was spiritually and culturally aware. It provided focused care for dying and deceased patients and their relatives.
- The previous inspection acknowledged that the EOLC service at the hospital was well led at a local level but was unable to find consistent evidence that EOLC was a priority for the trust board. At this inspection the EOLC team had board representation and a dedicated clinical lead who was trust wide.
- The EOLC team had a risk register, governance meetings and a strategy and steering group. The trust was committed to delivering excellent EOLC for all patients. The leadership of the hospital and the team working within the palliative care team, delivered care of a high standard and were proud of the service they provided.
- The trust culture encouraged candour, openness and honesty.
- The hospital palliative care team embraced the acquisition with Frimley Health NHS Foundation Trust and the re-organisation of services this initiated. Through this transition the team continued to deliver both patient care and a trust wide education programme.

### Vision and strategy for this service

- The hospital had a vision to ensure that EOLC was consistent with a trust wide approach. This was to be delivered in a timely, sensitively, spiritually and culturally aware manner, with appropriate patient and relatives focused care of the dying and deceased patients.
- We saw that the trust wide EOLC five year strategy had been written and was underpinned by a clear action plan. The vision, values and strategy were being developed in line with all who were involved in the EOLC steering group.
- The vision of the service was to streamline the discharge pathway. By empowering ward staff to discharge EOLC patients in a timely manner and ensure adequate support services in the community that enabled patients to return home if that was their wish.
- The leadership of the EOLC service recognised that they needed to identify the dying patient earlier and keep EOLC as the focus. They told us that 45% of patients die who were on 'Care Plan for the Dying Patient' pathway and 50% of these had died within 24 hours of its instigation.

### Governance, risk management and quality measurement

- The hospital had an EOLC steering group which met quarterly. All serious incidents, complaints, clinical incidents were reviewed and appropriate actions taken and changes made to any training plans.
- We saw minutes of the steering group meetings which were well attended by representatives across the hospital who were involved in the care of an EOLC patient. The chair was the trust EOLC clinical lead. There was board representation as well as the deputy director of nursing and medicine attending.
- There was a Wexham Park Hospital Supportive and Palliative Care Multidisciplinary Team Annual Report for 2014/2015. This described the staffing, workload and the challenges set for 2015/2016.
- There was an EOLC risk register with action plan and review dates. At the time of inspection the risk register contained incidents relating to care after death, staffing of palliative care provision, syringe drivers, DNACPR and discharge pathways.
- The National Care of the Dying audit 2014 recommends that all hospitals undertake local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually.

# End of life care

- At the time of inspection the hospital did not have a working EOLC survey. We were assured that a new patient satisfaction survey and bereavement survey had been developed and would be implemented by the end of 2015.

### Leadership of service

- At the last inspection we found that the EOLC services were well led at a local level but not at trust board level.
- At this inspection we saw that the trust was committed to delivering excellent EOLC for all patients. Since the acquisition by Frimley Health NHS Foundation Trust the hospital had a named board lead trust wide and an EOLC clinical lead, who was an urology consultant.
- The hospital leadership and the team working within the palliative care team were of a high standard and this was confirmed by all staff we spoke with.
- The hospital EOLC consultant told us they were very proud of the palliative care team who worked very hard to perform exceptional care to EOLC patients. Also they were proud of providing a service seven days a week and adjusting to the recent changes in the computer systems.

### Culture within the service

- We were told by staff and the senior team that the trust culture encourages candour, openness and honesty.
- Consultants we spoke with recently felt more able to engage with senior management.
- Staff on Eden ward and ward 5 told us they were positive about the acquisition by Frimley Health NHS Foundation Trust and felt confident about the future. They were aware of the changes and acknowledged that it was a slow process. Staff on ward 20 told us they had 'grown with the trust', were adaptable and embraced the changes.

### Public engagement

- The palliative care team last completed an annual patient/carer survey in 2013. At the time of inspection the hospital did not have a working EOLC, patient satisfaction or bereavement survey. We were assured that plans were in place to collaborate a trust wide monthly patient satisfaction survey. Additionally they were developing a bereaved relative's survey of experience to provide immediate feedback to wards and services.
- The hospital and palliative care team worked closely with Healthwatch and the Patient Panel and they were involved in the development of the 'Care Plan for the Dying Patient'.

### Staff engagement

- Staff told us they were actively encouraged to express their views which could help to develop services. We were told that a business case has been developed to increase the number of occupational therapists providing palliative care which would assist the discharge process.
- The palliative care team told us they were actively encouraged to report any concerns regarding wards that may affect the care of an EOLC patient. For example, staff shortages and training issues.

### Innovation, improvement and sustainability

- The chaplaincy team had recently won an award from the 'International Journal of Palliative Nursing' for their innovation in palliative care.
- The hospital palliative care team continued to deliver both patient care and a trust wide education programme whilst embracing the acquisition by Frimley Health NHS Foundation Trust and the re-organisation of services. They had built an external relationship with the commissioners of EOLC in both East Berkshire and South Buckinghamshire to take service improvements forward.
- The leadership of the EOLC team were examining a joint working model with community services to maintain sustainability. The hospice had business plans in place for the future of palliative care at the hospice and the hospital's EOLC team were proactive in their plans to work with them in an integrated manner.
- The palliative team as a multidisciplinary team resourced the expertise of its colleagues to ensure the continued individualised care for patients at the end of their lives.
- Working in collaboration with other members of the multidisciplinary team enabled two patients who were in the dying phase of their illness to be discharged home to die. The learning from these case studies formed the basis of a training conference to highlight the wishes of the patient and their treatment goals. The fundamental lessons learned was to accommodate patients who wished to spend their final days at home with their families.

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Wexham Park Hospital offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital has 41 medical and surgical specialty clinics, as well as paediatric and obstetric clinics. There were 251,810 outpatient appointments at the hospital in the last calendar year.

The diagnostic imaging department carried out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. In the last year, 226,194 people used this service.

During the inspection, we spoke with 113 members of staff, which included managers, nurses, administrative staff and allied health professionals. We spoke with 29 patients and their relatives. We visited all outpatient areas, the booking centre and all areas of diagnostic imaging.

At our last inspection of Wexham Park, we rated the outpatients and diagnostic imaging departments as required improvement. We found that some improvements were required to keep outpatients services safe for people at Wexham Park Hospital. These included better infection control and systems. Insufficient work had been done to improve the booking and appointments systems, waiting times, and the cancellation of clinics. During this inspection, it was clear improvements had been made in several areas.

## Summary of findings

Overall we rated the outpatients and diagnostic imaging departments at Wexham Park Hospital as 'Good' this was because:

- The hospital consistently met waiting and treatment times in line with national standards. Professional staff treated patients with kindness, dignity and respect. The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.
- The booking centres had processes to ensure patients received appointments within the appropriate timeframe. There were fail-safes in place and medical staff assisted management if required. Medical record management enabled clinicians in outpatients to have access to patients' records more than 99% of the time. The radiology department had worked to reduce waiting times in the past year,
- Staff were competent , professional and treated patients with dignity and respect. The outpatient and diagnostic imaging department appeared clean and well maintained. Staff demonstrated good infection control practices . Equipment was serviced and maintained regularly.
- Every member of every team contributed positively to patient care. All staff shared the vision and values of the hospital and good leadership was visible at all levels. Staff worked hard to deliver improvements in

# Outpatients and diagnostic imaging

their departments. They were proud of their achievements and had the vision and energy to continue with improvements and develop services further.

## Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatients and diagnostic imaging at Wexham Park Hospital 'Good' for 'Safe' because:

- During our last inspection we saw improvements were required in infection control systems. During this inspection we saw good infection control practises and process in place.
- Robust systems had been established to monitor safety throughout the service. Staff within these departments understood incident-reporting processes. There was feedback and learning from incidents, through all staff levels. Clear and consistently followed standard operating procedures were in place and policies helped keep patients from harm. Medicines were stored and managed safely and securely.
- Health records management was outstanding and more than 99% of records were available to staff working in clinics.
- Equipment was serviced regularly and in the diagnostic imaging department equipment was maintained in line with the standards required. The waiting areas and clinic rooms appeared clean and well maintained, however regular cleaning was not recorded consistently.

### Incidents

- Staff reported incidents using an electronic reporting system. Outpatient staff discussed incidents at a daily communication meeting. We saw that outpatient service managers displayed information relating to incidents on a communication board in the staff room. Senior nurses reviewed information about reported incidents at the senior nurses meeting and the governance meeting for the directorate. Managers passed any lessons learned at governance meetings back to their teams and displayed this information on the communication board.
- Clinical governance meetings occurred every month, where radiology staff discussed learning from incidents. Staff in radiology gave us examples of changes made because of an incident. The introduction of a pause and check system in radiology was because of an incident reported to the CQC. In April 2015 the department had a

review of these checks. It showed that 100% of radiographers checked the identification of the patient and documented this on the request form. This was in line with the identification check policy.

**Cleanliness, infection control and hygiene**

- Hand gel was available throughout the main reception and outpatient waiting areas. There was clear signage indicating the importance of hand hygiene. In clinic rooms there was '5 steps to hand hygiene' guidance on the hand washing dispensers. This was in line with World Health Organisation advice. Posters on clinic rooms walls encouraged patients to ask staff members to wash their hands if they did not see them doing so. Hand gel was available on every desk in each treatment room. There was a hand washing basin in every room we saw. We saw staff in clean uniforms and bare below the elbow. However, we did not see any staff or patients using the hand gel as they entered and left the outpatient department, during our inspection. The hand hygiene audit score for the last month was 100%, which was greater than the target score. We were unable to see staff hand washing between patients, as clinic room doors were shut when patients attended.
- Daily cleaning checklists, which included equipment cleaning, were on the back of each clinic door. Of the four cleaning checklists, we saw (rooms three, four, five and 14), the checklist had been completed 51 times out of a possible 153, when the clinics ran. This meant we could not be sure that regular cleaning checks of the ward or equipment were taking place. However, rooms and equipment looked clean. There was no dust visible on rails or skirting boards when checked. We saw green 'I am clean' labels in an equipment cupboard. We did not see green labels on any equipment to indicate it had been cleaned.
- Disposable curtains were in all clinic rooms we visited. They were clean, free of dust, and labelled and dated. The dates were within six months of the inspection.
- The most recent score for the infection control and hygiene audit in outpatients was 95%. Hand gel sanitizer, personal protective equipment and sharps bins were available in all rooms we looked in.
- The endoscopes used in the ear, nose and throat (ENT) clinics were cleaned between each use with a triple cleaning system. At each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff used. The records showed each time an endoscope was cleaned with the three stages completed. At the end of the clinic, staff placed all of the scopes used in a red tray and took them to the endoscopy unit, where they had additional cleaning. Other instruments in ENT were single use, which minimised infection to patients. However, in clinic rooms three and five, some pieces of equipment were reusable. They had been sterilised, but in clinic room three their expiry date was 10th June 2014 and 12th August 2014. In clinic room five the expiry date for one piece of equipment was 6th November 2011 and another had no date of expiry on it.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed and by who.
- In the radiology department, they demonstrated regular cleaning of rooms and equipment with checklists. The most recent cleaning score sheet audit scored an average of 99% in clinical areas.

**Environment and equipment**

- At the main reception desk, there was no barrier or sign to keep queuing patients at a confidential distance. Patients booking in could be overheard which could result in a breach of confidentiality. Staff told us there used to be a barrier and a sign, but that it had been removed. We saw a wheelchair accessible waiting desk at the main reception.
- The outpatient area had separate clinic areas, with dedicated waiting areas for each clinic. Seating was made of wipe clean fabric with some higher chairs available. Waiting areas suitable for children had toys available. Staff cleaned toys every evening
- All electrical equipment in rooms we visited had a recent portable appliance test, which indicated the equipment was safe to use. We saw complete and up to date service records, for equipment serviced yearly.

# Outpatients and diagnostic imaging

- The resuscitation trolley in outpatients was a sealed unit and checked daily by two members of staff. The resuscitation trolley in radiology had daily checks and we saw complete checklists.
- We saw appropriate warning signs and lights outside of rooms in accordance with ionising radiation (medical exposure) regulations (IR (ME) R 2000). The Radiation Protection Advisor performed an annual quality assurance (QA) check on equipment in the radiology department. Departmental staff also carried out regular QA checks. This indicated equipment was working, as it should. These mandatory checks were in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- Lead aprons were available and checked regularly. The next checks were due in November 2015
- The waiting area for blood tests was small, with waiting patients overflowing into the corridor in the morning of our inspection. This waiting area was empty in the afternoon. The manager had submitted a business case to extend the waiting area. This would provide an extra space for patients waiting in radiology. The radiology management team told us this was now being actioned. In addition to this, there would be space for extra treatment areas for patients having blood tests.
- The computerised tomography (CT) scanner was on the trust risk register. A local scanner had been installed but unavailable for use at the time of inspection and the scanner at Wexham Park was a single point of failure. A mobile CT scanner had been available for use if the scanner at the hospital failed. There had been no significant incidences of service interruption reported as a result of the scanner failure. Planning and funding was in place to go ahead with a project to install a new CT scanner at Wexham park..

**Medicines**

- Medicines in outpatients were stored in locked cupboards. The key to the medicine cupboard was stored in a locked cupboard and a registered health professional held the key to this cupboard. This was in line with good medicines management.
- Prescription pads were stored in a locked cabinet. If a prescription pad was required, a registered member of staff signed it out and signed it in again when returned. Staff documented the serial number of the prescription pad, along with the hospital number of the patient and the medication prescribed. This demonstrated safe and secure management of prescription pads.
- Staff had a good understanding of the policy for giving contrast media out of hours. We saw the policy, which was in date and in line with royal college of radiographer standards.
- Medicines in radiology were stored in a locked cupboard. Controlled drugs were stored in a double locked cupboard and a registered health professional held the keys. This was in line with standards for medicines management. Staff checked medicines daily and all medicines we saw were in date. Staff checked and ordered medicines weekly to keep adequate supplies and manage stock.
- Patient group directives (PGD) provide a legal framework for the administration of medicine by a registered healthcare professional. In radiology out of three PGDs we saw, one should have been reviewed in May 2015, one was due for review in October 2015 and one was due for review in September 2016.

**Records**

- Staff from medical records brought patients notes to clinic every morning. Staff put notes in a locked trolley in the appropriate clinical area. A member of staff held the key to the trolley and took out patient's notes as required. We saw the locked trolley and members of staff removing notes as required. This demonstrated that notes were being stored safely and securely in accordance with the data protection act, 1998.
- Reception staff placed a patient's notes face down once they had booked in, to maintain confidentiality. A coloured form in the patient's records helped the doctor or nurse to inform reception staff of when the patient needed their next appointment. The doctor indicated on the form, when the patient needed to return to clinic. Patients returned the form to the reception desk, following their appointment. The reception staff put this information into the computer system. Staff closed the clinic list when every patient had another appointment or outcome. This prevented patients being lost in the system.
- We looked at 10 sets of medical records. All notes were legible, dated and signed, which was in accordance with the hospitals documentation policy. We saw documented evidence of consent and risk assessments.

- The availability of medical records for patients attending outpatients was regularly greater than 99% for the past 12 months. The hospital target was 99%. The most recent audit of medical records showed that 0.2% of medical records were not available the month prior to inspection. Over last the 12 months, 0.3% of incidents relating to medical records were because medical notes were unavailable.

**Safeguarding**

- Staff demonstrated good knowledge about how to manage any safeguarding concerns. All staff named the named nurse for both adult and children safeguarding concerns. The names and contact details of these nurses were clearly visible in staff only areas. The computer system could alert staff to any on-going safeguarding concerns and was only visible to staff. If a child did not attend their first appointment another appointment was sent. If they did not attend a second, the Consultant would review the child's notes and appropriate further action was taken. There were two safeguarding alerts made in outpatients in the past 12 months.
- In the radiology department, all staff had completed level one and two safeguarding children and vulnerable adult training. All Band 7 staff and above had level three safeguarding children training, which was in line with in the Safeguarding Vulnerable groups Act 2010. It also followed the royal college of paediatric child health guidance, 2010, for staff interacting with children.
- Staff could chaperone in the radiology department in accordance with the royal college of radiography guidelines. In the outpatient department, staff could chaperone in accordance with the trust's chaperone policy.

**Mandatory training**

- Nursing staff told us they had protected time in order to remain up to date with essential training. Ninety-two percent of nursing staff had completed once yearly essential training within the period. All staff had completed their essential training required within the three yearly timescale. Essential training had included moving and handling, safeguarding, mental capacity and infection control.
- All staff in radiology felt they did not have time to complete essential training because staff numbers were low; 78% had completed their essential training within the required period.

**Assessing and responding to patient risk**

- There was a comprehensive failsafe system in place for the management of referrals for suspected cancer. A referral received into the booking centre from GP fax and scanned onto computer. On receipt of the referral, the GP received notification. If the GP did not receive a fax within 48 hours (alerted via computer), an alert arose. A medical team looked at referrals on this pathway to check they were on the correct pathway. Bookings staff put the referral into a computer folder for the relevant speciality and the patient telephoned with an appointment. This was in accordance with the access policy for cancer patients and followed the standard operating procedure for booking patients with suspected cancer. It gave assurance that patients in this group received their first appointment in a timely manner. In addition to this, the booking centre had identified some patients cancelling or not accepting their appointment as they were not aware of the importance of it. They had devised a form to prompt the referring GPs to highlight to patients with suspected cancer the importance of attending their appointment as soon as possible
- Medical staff monitored referrals, so they received treatment at the right time. Doctors looked regularly at choose and book referrals, suspected cancer referrals and patients that did not attend. They assessed whether they needed to an appointment sooner rather than later or could be discharged, if another appointment was not needed. This was supported by weekly tracking list meeting, which monitored where patients were on the pathway, for outpatients and radiology
- Unwell patients often came to the main reception area on their way to the emergency department. There had been some instances were these patients had become more unwell. Because of this, the outpatient leads had decided that all staff in outpatients should have intermediate life support training. This would help staff to be able to deal with these patients quickly and appropriately. The plan was to achieve this by December 2015.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local

rules were available in all areas we visited and signed by all members of staff. Radiology staff had a clear understanding of out-of-hours protocols and policies. Exposure charts give details of the recommended amount of ionising radiation to obtain an x-ray image of diagnostic quality. We saw exposure charts were on file and in date.

- Radiology department policies and protocols were mostly up to date. However, the fire safety policy, fire risk assessment and fire emergency plan were out of date. Managers were reviewing the policy for management of emergencies at the time of inspection. Policies were in the process of being combined with trust wide policies
- Staff carried out regular risk assessments on patients. They explained if a patient attended at the upper end of the weight limit for equipment, they would consult the bariatric nurse. A, risk assessment would be done, but not formally recorded. This was in accordance with the management of the bariatric patient policy. It is also in line with guide to the handling of people under Health and Safety at work Act, 1974.

### Nursing staffing

- At least one trained and one untrained nurse staffed the outpatient department during clinic opening times. The department did not use agency staff. The department would use their own staff as bank, if they needed additional staff.

### Radiology staffing

- At the time of our inspection, the radiology department was operating with more than 14 whole time equivalent posts below their establishment. In order to deal with this shortfall, staff ran the department by working a dayshift after a 12-hour night shift. This meant they could sometimes work for a 24 hour period. Staff turnover was consistently worse than the 12% target at 16.38% . Managers told us a new post had been created to deal with recruitment and retention. In addition to this they had recruited their own students and had agency staff to support.

### Medical staffing

- There was a radiologist available in the department until 8pm every weekday, then available on call. In addition to this, a radiologist was available from 9am to 5pm at the weekend.
- Outpatient medical staff told us they received good support from consultants in clinic. A clinic would not run, if there were no consultant available.

### Major incident awareness and training

- Several staff gave us an account of the process within the department in the event of a major incident. This was in line with the major incident policy.

## Are outpatient and diagnostic imaging services effective?

**Not sufficient evidence to rate**

- Staff in the outpatients departments had good awareness of the best practise guidelines for treatment and medicines management. Both the outpatient and radiology departments demonstrated following the national institute of clinical excellence (NICE) guidelines. Both departments had undertaken local audits and there was a plan of clinical audits to be undertaken.
- There was evidence of good team working in clinics, the radiology department and across the specialities. Outpatients clinics ran in the in the evenings and at weekends. The radiology department provided a 24 hour a day, seven days a week on call service.
- Staff were competent in the outpatients and radiology departments we saw documentary evidence to support this.

### Evidence-based care and treatment

- The diagnostic imaging department was following a variety of national institute of clinical excellence (NICE) guidelines. They met NICE guideline, CG68 for the diagnosis and initial management of acute stroke and transient ischemic attack (TIA) All patients were scanned within the hour if a suspected stroke occurred on Hospital grounds. NICE guideline, CG112 for sedation in children and young people was followed as all children undergoing an MRI were sedated. Staff in radiology met the guidelines for imaging the spine in known cancer, NICE guideline, CG 75. Patients had access to urgent magnetic resonance imaging (MRI) within 24 hours .

There was also an on-going audit for true cord compression. In addition to this there were a number of local audits taking place in relation to infection control and hand hygiene.

- The imaging department had policies and procedures in place. Six policies we saw were in date and staff had a good understanding of them. Fire risk assessment was due to be done in July 2015, but had not. Radiography policies we saw were in line with regulations under IR (ME) R and in accordance with the royal college of radiologist's standards.
- In outpatients all chronic heart failure patients were seen by a specialist and had an echocardiogram within 2 weeks of referral. This was in line with NICE guideline QS9. The average outpatient echocardiogram turnaround time was 2-weeks when last audited. A weekly outpatient clinic had been established to ensure all patients diagnosed with venous thromboembolism (VTE) events had a review as per NICE Guidelines, QS29. At the clinic, aspects of anti-coagulation were reviewed and clarified, whilst appropriate patients could be investigated for underlying causes of VTE.
- In the plaster room, staff had been using a boot for the conservative management of achilles tendonitis. They planned to present the results at an international conference.

**Pain relief**

- Analgesia was available in the radiology department for patients in pain, if they required it.

**Patient outcomes**Patient outcomes recorded on the computer system indicated if a patient had another appointment, or had been discharged. Staff could not close a clinic without inputting an outcome. This indicated all patients had an outc**Competent staff**

- In radiology we saw competency documents which indicated staff had competence in a variety of skills, required to perform their duties safely. This included working at night, in theatre and in the justification of plain x-ray examinations. They ran a development programme which involved a six month induction to Band 6 level.
- Agency staff in radiology signed a document to indicate they had read policies and local rules. We saw these documents, all staff had signed them.
- We saw the induction pack which included the hospitals values, complaints management, consent process and incident reporting.
- The radiology department stored a list of people able to refer patients for a test. This gave assurance people referring patients for diagnostic tests were competent to do so.
- Staff in outpatients and radiology told us they had appraisal, but did not always have documentary evidence of this. In radiology all staff had completed an appraisal or one booked . In outpatients 13 of 21 staff had an up to date appraisal, three were due within the next month and five were overdue. The hospital stated the current system of recording appraisal completion was failing to capture all activity. It required the appraiser/manager to actively record the appraisal date and ratings after the appraisal discussion and as a separate process. They aimed to move the appraisal process from paper based to electronic system which would result in more accurate reporting of appraisal completion.
- Staff overall felt over the past year they had the opportunity to develop. However, some staff told us they had their training requests declined because of staffing shortages in radiology. The radiology manager told us he was not aware any training requests had been declined.
- Staff in radiology felt low staffing levels had affected their training levels. They could not attend training identified in their personal development plans because of lack of staff to cover in their absence. When we discussed this with the radiology manager, he was unaware this was the case. Staff in radiology had appraisals to complete contributed to their continuing professional development. Seventy-four percent of radiology staff had completed their appraisal.
- Staff felt their appraisal was meaningful and the introduction of values has given the process more structure. 14 of 17 staff nurses that were eligible for an appraisal had completed it. Two other staff had booked their appraisal within the week following our inspection.

**Multidisciplinary working**

- The transient ischaemic attack (TIA) rapid access clinic provided a 'one-stop' clinic for patients identified as having a potential for low risk TIA. The clinic saw patients within 7 days. The clinic ran Monday's, Wednesday's and Friday's providing access to

diagnostics tests to aid diagnosis and on-going management. Staff gave patients a management plan. They sent a summary to the General Practitioner (GP). The clinic discharged most patients, but some received another appointment if it was necessary.

- The rapid access chest pain clinic saw patients sent from their GP for suspected angina or with a new onset of chest pain. The clinic saw patients within 14 days of referral. Clinics were nurse led and run daily at the hospital. Patients had appropriate tests and were discharged to their GP if their chest pain was not cardiac in origin. The nurses followed up the results and gave feedback to both the patient and GP.
- Radiology staff members attended 22 different speciality, multidisciplinary teams.
- There was good team working between the booking centre team, service managers**,** imaging team and clinicians to manage waiting lists and breaches.
- The radiology department had provided imaging support for one-stop clinics to for a number of specialities. It also provided support for multidisciplinary team meetings.

### Seven-day services

- Radiology consultants worked seven days a week. The radiology department provided a seven day, on call service.

### Access to information

- Staff had access to full medical records more than 99% of the time in the last 12 months. This was better than the target score of 99%.
- Radiology examinations were available on a secure computer system. Staff had individual pass codes to log on to the system.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- An audit of consent was complete in the computerised tomography department. There was 100% compliance in staff gaining patients consent.
- In medical records we looked at, consent was documented. There were consent forms available in all ear, nose and throat (ENT) rooms. These covered consenting patients and clinical procedures.
- 64% of nursing staff had received training in the Mental Capacity Act.

## Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatients and diagnostic imaging departments at Wexham Park Hospital 'good' for 'caring' because:

- Staff continued to treat patients with kindness, respect and staff they interacted with behaved in a very professional manner. Patients we spoke with were happy with the care they received and told us staff had given them good explanations about their care. They told us staff treated them with dignity and respect at all times.
- We saw staff had processes in place to respect patient's dignity and respond to their individual needs. We saw staff interacting with patients in caring and respectful manner. We witnessed staff informing patients of any clinic delays and giving the reasons for those delays.

### Compassionate care

- Friends and family tests were available at the reception desk and advertised in 10 different languages. For the June, July and August 3397 patients responded on average each month. During that period, 94% of patients would recommend the hospital and 2 % would not.
- In radiology the last friends and family test was 98% patients would recommend the service and less than 1% of patients would not recommend the service. This was better than the England average for outpatient services which is that 92% patients would recommend services and 3% would not
- Patients felt that staff were friendly, efficient, and professional and provided a good service. We saw a member staff take a patient away from the main entrance of the department as it was cold, to a warmer area. In another area, a member of staff gave a colouring book to an upset child. We saw staff dealing with an unhappy patient in a very professional manner. Staff in outpatients and diagnostic imaging dealt with patients in a courteous and skilled manner.
- In outpatients, there were individual clinic rooms, with signs on doors to provide privacy for patients. In radiology, the layout of the waiting area made it difficult

to preserve patient's dignity, when they were on a trolley. Curtains were in place in this area, but only went around the trolley half way. This left the patients visible to others waiting or walking through the department. The hospital had plans in place to expand and alter this waiting area to deal with this.

**Understanding and involvement of patients and those close to them**

- Patients we spoke with told us they had received enough information prior to their appointment and that the team treating them had given a good explanation of the investigations they were going to have and why.
- We saw there were a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to common ailments. This literature was available in all waiting areas of the outpatients departments.

**Emotional support**

- Information boards displayed information about support available from Macmillan nurses for patients living with cancer. There was also advice about support available for those patients trying to stop smoking. In addition to this, advice about giving up smoking and a link to a website was routinely on the back of appointment clinic letters. There were also carers support group advice and information about who to contact.

## Are outpatient and diagnostic imaging services responsive?

Good

We rated the outpatients and diagnostic imaging departments at Wexham Park Hospital 'good' for 'responsive' because:

- During our last inspection we saw that insufficient work had been done to improve the booking and appointments systems, waiting times, and the cancellation of clinics. During this inspection we saw that staff monitored clinic waits and service managers were contacted if there were delays of more than an hour. The booking centre had good systems and processes in place to ensure that all patients received an appropriate appointment in a timely manner.
- At the last inspection there were delays in diagnostic imaging department, which meant patients were not having investigations carried out as planned prior to a follow up appointment. At this inspection we saw that significant improvements had been made in diagnostic imaging and patients were accessing their investigations in a timely manner.
- The outpatient and diagnostic imaging departments had made huge improvements in their waiting times over the past 12 months. This was with an increase in patient numbers referred. The booking centres for both departments had put systems in place to be able to ensure patients received their appointments in line with national standards. Multidisciplinary working enabled departments to work together in the management of waiting lists.
- There were good systems and processes in place to be able to plan and manage waiting times for outpatients and diagnostic imaging departments.

**Service planning and delivery to meet the needs of local people**

- Monitoring capacity and demand enabled the radiology department to respond by increasing capacity for some specialities such as ultrasound and computerised tomography. This had led to a reduction in patients waiting for longer than 6 weeks. The hospital saw 84% of patients in less than four weeks and 94% of patients in less than five weeks.
- The radiology department had changed to a walk in service on weekdays for GP referrals for general X-Ray. There was also an increase in accessibility, for outpatients with the department open until 8pm.
- The introduction of an extended working day and seven day working for consultants supported the inpatient workflow and reduced the waiting time for those patients. In addition to this staff were aiming to do "today's work today", which had helped to reduce inpatients waiting times.
- The radiology department provided a walk-in service for patients referred from their GP for an X-ray. This service was available from 8am to 8pm. Waiting time had

reduced consistently over the last 12 months. The department saw eighty-four percent of patients in less than 4 weeks and 94% in less than five weeks. The number of patients waiting longer than 6 weeks had fallen from 241 in January 2015 to none in July 2015. Senior staff had used a tool to monitor capacity and demand. This enabled the department to respond by increasing capacity for specialities such as ultrasound and computerised tomography. Extra capacity to manage equipment breakdown and waiting list initiatives was provided by mobile vans on an ad hoc basis. Ultrasound appointments were available from 5pm-8pm for patients that could not attend during working hours.

- The radiology and outpatient booking centres had daily access to a patient-tracking list. This enabled them to monitor patient pathways and ensure patients accessed their treatment in a timely manner.
- In the outpatient department the rate at which patients did not attend their appointment was 8%. A text reminder service was in place. In addition to this, matron told us there were plans in place to introduce a two-way text reminder, so patients could change their appointment if necessary.
- Several patients identified finding a car parking space as a problem. Some patients told us they chose to attend the hospital a long time prior to their appointment because it was so difficult to find a space in the car park. Others told us they chose to get a taxi, to avoid using the car park. The hospital had plans in place to increase the number of car parking spaces

**Access and flow**

- The incomplete referral to treatment (RTT) standard is that at the end of each month 92% of all patients waiting to start treatment should have been waiting for less than 18 weeks. The incomplete pathways for this hospital was 92.7%. With half of all patients waiting seen within seven weeks.
- 95% of patients referred for an urgent appointment, received one within two weeks. This was better than the England average. This was the same for patients accessing treatment within 31 and 62 weeks also. This indicated patients could access first appointments and treatment quicker than the England average.
- The radiology department had reduced waiting times significantly over a twelve-month period. At the start of the year, waiting times for diagnostic tests were much greater than the England average.
- At the time of inspection and since March, the waiting times for diagnostic tests had reduced to lower than the England average for all diagnostic tests. The average waiting time for a diagnostic test was 20 days for outpatients, 14 days for GP referrals and one and a half days for referrals form A & E. The number of radiology breaches had reduced from 241 in January 2015 to zero the month prior to and during inspection. The rate of patients not attending their appointments remained higher than the England average. The radiology department displayed the waiting time for patients to see. At the time of inspection, the waiting time for all patients was 45 minutes.
- Radiologists and radiographers reviewed each request that came into the department. This was to check the examination was suitable for the patient. Staff reviewed inpatient requests within three to four hours. Outpatient's requests took 24 hours to review. This helped to minimise the wait patients had for their examination.
- At the time of inspection, there were 2198 reports awaiting a report, 710 of these were for patients on the suspected cancer pathway. The radiology managers told us that if a test had no report after a five day period, an external company would do the report, which would minimize delay for patients on the suspected cancer pathway.
- Wexham Park Hospital had a did not attend (DNA) rate of 8% compared with the national average of 7%. Matron had audited the reasons for patients not attending and had put processes in place to reduce the rate of non-attendance. She was planning to re audit to see the effect of these changes.
- During the time of inspection, we saw that a clinic was one doctor short. When the waiting time for patients reached one hour, the nurse in charge completed an incident form. The operations manager arranged for a doctor to come and cover the clinic. Patients had the choice to wait or to have a pager, so they could go outside to get a drink or to rebook their appointment.
- The phlebotomy waiting area was very small. This meant at peak times, patients had to wait standing up. During the inspection, we saw more than 30 patients waiting at one time for a blood test in the morning. In

the afternoon, no one was waiting. Because of patients requiring blood tests after not eating, there was a peak in activity in the morning. The phlebotomy department had extended its opening times, by putting an extra hour on the clinic at each end of the day and opening Saturday mornings. Numbers of phlebotomists did not increase at peak times.

- The plaster room was a nurse led clinic. They operated a ticketing system, so patients would be see in order of arrival to the department. Over the past year, the recorded average waiting time in outpatients' clinics was nine minutes.
- Hospital policy stated a letter from clinic should be sent to the GP within five working days. In June, July and August, the average time it took to send out clinic letters was consistently lower than this at four, three and three days. This was in line the trust standard .
- Between June and August 2015, the call centre answered 97% of calls within 60 seconds, and 99% in 90 seconds. This indicated the vast majority of callers were able to get through with little wait.
- Between April and July 2015, the hospital cancelled 3% of clinics six weeks before appointment date. The hospital cancelled 18% of patient's appointments within six weeks of the date. Reasons for cancellation within six weeks were; 48% due to Annual Leave, 22% due to on call or changes to the rota and 20% as the clinic capacity was inadequate. The hospital policy was not always being followed as it stated that six weeks' notice should be given for annual leave.

**Meeting people's individual needs**

- In the outpatients department, there were clear signage on the toilet doors, which had both words and a picture. This made it easier for patients with a diagnosis of dementia and those for whom English was not a first language to identify. In addition to this, dementia clocks had been ordered, by the outpatient team for use in the waiting areas. In radiology, staff had designed a patient information leaflet specifically for children.
- There was a robust process in place for urgent referrals. The GP faxed a referral to the booking centre. The cancer team dealt with all referrals daily and transferred referrals straight into the appropriate teams' electronic folder. The patient received an appointment by telephone. If the patient was unable to attend within two weeks staff contacted the service manager to deal with it further.
- The friends and family test was available in 10 different languages at the main reception desk. Translators were available and requested prior to a patient appointment. There was also a telephone translation service available.
- A computerised information system showed booking centre staff in outpatients and radiology appointment availability across all sites. Staff offered patients a choice of where they could attend their appointments.
- In outpatients and radiology patients with learning disabilities and dementia were seen in the next available appointment, to reduce their waiting time.
- Ultrasound appointment letters informed patients they may be seen by a member of staff of the opposite sex. If they wanted to have a test performed by a member of staff of the same sex, the opportunity was given for them to call the department to arrange this.
- There was a quiet room available in the outpatient department, which staff could access if bad news had to be broken.

**Learning from complaints and concerns**

- Leaflets informing patients how to make complaints were available in waiting areas. Staff felt able to handle complaints and preferred to do so at a local level to diffuse the situation. We saw a member of reception staff dealing with an unhappy patient in a very professional manner.
- Staff told us patients had complained about extra car park fees if a clinic over ran. In response to this, if a patient waited longer than anticipated, the hospital would pay for the additional cost of car parking. This arrangement was confirmed by the car parking supervisor.

## Are outpatient and diagnostic imaging services well-led?

Good

We rated the outpatients and diagnostic imaging departments at Wexham Park Hospital as 'good' for well-led' because:

- At the previous inspection we saw that improvements were required to ensure that the service was well-led. At a local level there was good leadership, but this needed to be improved at senior management level to improve

communication, learning, and improvements in outpatients. Following the acquisition of Wexham Park Hospital by Frimley Health NHS Foundation Trust in 2014, the trust's values, vision and strategic plan was reviewed and revised. During this inspection we saw the Trusts values were well embedded in the appraisal system and staff engagement was high.

- A clear leadership of service had been established. Staff knew their responsibilities and engagement was high through all staff levels. There was a positive culture within outpatients and radiology departments. There was a clear strategy for the development of services further and all staff were aware of this and their role in contributing to it.
- The appraisal system was well embedded and linked to the trust values. Quality of services provided was measured regularly and improvements to services was on-going. Staff and managers had a shared vision of continuous improvement to patient centred services.

**Vision and strategy for this service**

- Staff had good awareness and knowledge of the vision for the hospital. There was a real sense everyone was working together for the same aim. Values were embedded in appraisal systems and staff spoke proudly about their achievements and working at the hospital. In addition to this, they were driven in delivering further improvements to their service
- There was a comprehensive improvement plan in place across the hospital, staff we spoke with had a good understanding and awareness of the improvements. In addition to this, there was an outpatient transformation programme in place. Managers based the outpatient transformation programme around seven pledges made to patients around whom the department would plan its work stream.
- The booking centre and clinicians were working with managers to assess and deliver outpatient services.

**Governance, risk management and quality measurement**

- There was a variety of local audits on-going in outpatients. Audits of medical records were in line with information governance standards.
- There was also an on-going audit for true cord compression. In addition to this, there were a number of local audits taking place in relation to infection control and hand hygiene in both the radiology and outpatient departments.
- Clinical staff oversaw the management of referrals to outpatients and radiology, both urgent and non-urgent. There were many fail-safes in place to ensure that patients did not get lost in the system. The booking centre staff alerted service managers if issues arose.
- The radiology department was following policies and procedures in accordance with ionising radiation (medical exposure) regulations (IR(ME)R) regulations, 2000. Some policies were being reviewed with Frimley Park Trust.
- Did not attend (DNA) rates in outpatients were identified as being above the England average. The outpatient matron had audited this to understand why this may be. She identified areas of change and planned to re-audit following the inspection. This led to the implementation of a two-way text system.
- Outpatient and radiology departments regularly monitored waiting times, in order to plan future services. Clinics monitored waiting times, which allowed staff to see if there was a backlog in clinic and to deal with it as appropriate.
- At each clinical governance meeting staff discussed incidents, safeguarding, audits, nice guidelines, protocols, complaints risk register and appraisals. Staff developed action plans from this; we saw copies of the minutes of these meetings.
- A recent change was the introduction of booking centre staff to clinical governance meetings. This was a part of the outpatient transformation programme to improve staff engagement and multidisciplinary team working.

**Leadership of service**

- The Head of nursing was also the general manager for outpatients across Heatherwood and Wexham Park. There was a Matron for outpatients at Wexham Park. There was a chief of service for radiology and the radiology manager worked across Frimley Health. There were individual modality leads were based at Wexham Park.

- Staff felt their managers were approachable and they could discuss any issues with them. They were aware of who the senior managers and the changes on-going in the hospital. The senior management team were visible to staff on the floor and were contactable if issues arose.
- In radiology and outpatients, there were team meetings each morning, which enabled staff to discuss a variety of departmental issues. Staff received information about the friends and family tests via monthly email. Supportive relationships were evident in teams, between staff and managers.

**Culture within the service**

- There was a very positive culture within outpatients from all staff. Staff felt over the past year they had the opportunity to instigate and effect change and the change was sustainable. In addition to this, they felt there was more work to do to improve the service further. Staff at every level told us they felt supported by all other members of their teams and the senior management team. Many staff told us that there was a family feeling to the department, both in outpatients and radiology. Staff gave us several examples where students had applied for permanent positions in the hospital.
- Staff were encouraged to develop themselves further and were given the time and support to do so. Health care assistants had the opportunity to become mentors. Clinical nurse specialists had developed their roles and ran nurse led clinics. They attended conferences regularly and in turn provided teaching to others across the hospital. In radiology there was a programme to develop staff from one Band to another over a six month period. In addition to this, staff told us they had the opportunity to provide input into estate development plans.

**Public engagement**

- A public involvement group ran every three months. It involved the hospital meeting with Healthwatch groups and clinical commissioning groups. Regular patient experience forums discussed patient experience survey results. We saw minutes of these meetings which detailed changes made a result of patient feedback. An example of this was to display a posters detailing changes to car parking. Staff altered the process for dealing with cancelled patients as a result of these meetings. They clearly indicated priority patients on the medical records so a decision could be made to see them on the day or rebook in the next available appointment.

**Staff engagement**

- Staff spoke positively about working in outpatients. They had an excellent understanding of their roles. They felt able to raise concerns if any arose and felt they would be listened to and situations dealt with if they arose.
- Some staff in radiology felt their morale was low because of staff shortages. They felt their training needs were not being met because there was no time available to them to do so. Managers had recently introduced a radiology newsletter encouraging staff to come up with service improvement ideas. A suggestion from a member of staff had led to a pilot study to offer direct access for patients from the clinical commissioning groups (CCG) to the radiology department. It had been successful and was to be extended to other CCGs.

**Innovation, improvement and sustainability**

- The radiology department were part of the Oxford Academic Health Science network. This network brought together universities, industry and the NHS to improve health and prosperity in the region through sharing clinical innovation.
- The outpatient team at Wexham park monitored patients on the waiting list weekly which enable them to develop plans to manage demand within a timely manner. This linked to capacity and demand work and a review of patient pathways to sustain and develop services.
- The outpatient transformation programme involved seven separate projects in order to improve services further. It involved a review of coding cross site and capacity and demand modelling for outpatients . Managers reviewed clinic templates to optimise them and a looked at the productivity in clinics. This involved assessing clinic use and aimed to improve new to follow up ratios. Managers also looked at the use of clinic space and capacity across all sites. The booking process had been reviewed and a reduction in

patients who did not attend (DNA) was analysed by Matron. All of these projects were on-going and regularly monitored .The final project was to implement e-booking at the Frimley site.

# Outstanding practice and areas for improvement

## Outstanding practice

- Leadership in the Trust had inspired a culture shift since our last inspection that was evident across the hospital in all of the staff groups that we spoke with. Staff were proud to work in the hospital, and were committed to delivering care that met with the trusts values and vision.
- The improvements to patient flow through the ED meant that patients being seen within four hours had improved from 93% to 95% (meeting the national standard)and was being sustained consistently despite an increased number of people accessing the service.
- In critical care staff showed considerable innovation in meeting the individual needs of patients under exceptional circumstances.
- Staff engagement throughout outpatients and diagnostic imaging departments was outstanding. All staff were working towards common values, both clinicians, administrative and support staff, at all levels.
- The achievement of the radiology department to reduce and maintain their waiting times, in view of reduced staffing levels and equipment issues showed an outstanding commitment to improve patient experience.
- The improved booking centre processes in outpatients and radiology which involved multidisciplinary team members and ensured patients got the right appointment at the right time.
- Medical records were available more than 99% of the time, over the past 12 months.
- The roles of the five practice and development midwives were split between 50% clinical work and 50% administration and teaching workshops. One midwife worked every day in the labour ward to provide on the spot guidance and support to midwives.
- We observed outstanding prompt, appropriate and sensitive care and treatment provided for a woman in the labour ward who had complex and sensitive needs. Staff adhered to the comprehensive care plan they had developed to ensure the woman did not experience unnecessary distress.
- The hospital had comprehensive guidelines for staff in regards to female genital mutilation (FGM). The trust's safeguarding children annual report 2014/15 recorded that the identification of FGM had been an area of development for the trust. The trust had a policy of addressing FGM when booking women for maternity care.
- The hospital had a practice educator who had developed a comprehensive preceptorship programme for newly qualified nurses. This was a structured period of transition for the newly qualified nurses when they started their employment at the hospital. We viewed comments from newly qualified nurses' evaluation forms from their learning and found these to be consistently positive.
- The matron on children and young people's ward had received a trust recognition award for leadership.
- A senior nurse in critical care had been seconded into a research post for the year before returning to full time clinical duties. They had contributed to the application of the good clinical practice (GCP) guidance of the NIHR Clinical Research Network, which had been used to prepare a research working book for other nurses to use as a benchmark for research processes, from screening to final data analysis. The research was quality assessed by Monitor through site visits to check that research protocols adhered to gold standard clinical and ethical requirements. The lead research nurse had attended a GCP training course and had successfully been certified against national standards including ethics, legislation and application of the Mental Capacity Act (2005).
- One of the key research projects, VANISH (Vasopressin versus Noradrenaline as Initial therapy in Septic shock), had resulted in specialised one-to-one training packages for staff and an invitation for staff to present their findings at the European Intensive Care Society Conference in 2015. The study had looked at the avoidance of acute kidney injury through the use of steroids with inotropes and the results were presented to staff in the unit on completion of the study. Other projects included a study of the effectiveness of emergency laparotomies and a study of the translocation of bacteria in abdominal sepsis to

# Outstanding practice and areas for improvement

consider specific antibiotic therapy. The impact on nurses had been very positive and for three consecutive years, research-active staff had attended the European Intensive Care Society Meeting as recognition of their efforts towards establishing an active programme of testing best practice and treatment.

## Areas for improvement

### Action the hospital MUST take to improve

- The cleanliness of the hospital must be audited in line with standards set out in the national specifications for cleanliness in the NHS (NSC). This includes the correct classification of high risk and very high risk areas and the frequency of auditing in these areas. Audit processes should include a re-audit where areas are found to be less than 100% compliant. If the hospital chooses not to audit to NSC standards they must provide evidence of an equally robust auditing programme.
- Ensure that their policy around Candour (DoC) includes incidents resulting in 'psychological harm'. The provider must also ensure the policy is followed when managing incidents that come under this regulation.
- Continue with its delivery and the risk priorities associated with the backlog program. Fire risks associated with backlog need to be addressed as a priority.
- Improve Estates governance and ensure that up to date and approved policies and standard operating procedures (SOP's) are in place.
- Ensure that monitoring of weekly medicine stock checks in critical care is consistently applied and must ensure that the system in place to make sure out of date medicine is disposed of is audited.
- Ensure that resuscitation equipment is always checked according to the trust policy. The auditing system must include a visual check of the expiry dates of batteries
- Cleaning and storage materials in critical care must be stored in locked facilities and the lock for the cleaning cupboard must be replaced.
- Recruit to the three vacant consultant posts in ED. Although consultant cover in ED had improved since our last inspection the department still fell short of national standards.
- Ensure that all oxygen cylinders have an expiry date displayed, and system in place for staff to check that cylinders are within date.
- Continue to improve staffing recruitment and retention.

### Action the hospital SHOULD take to improve

# Outstanding practice and areas for improvement

- Ensure all staff in outpatients have development opportunities and training as agreed in their personal development plans.
- Ensure that regular and routine checks are made of the temperature of medication fridges.
- Consider plans for an additional CT scanner and integrated x-ray within the new emergency centre development planned for 2016.
- Improve pharmacy support for the emergency department and the decision unit (EDDU) in particular.
- Explore an effective means of explaining to patients why they have to wait to be treated in the ED.
- Consider testing the major incident plan which had recently been re-written.
- Consider the size and organisation of paper health records.
- Ensure the audit trail of medications delivered to wards is completed including the signature of the staff member receiving the medications on the ward.
- Consider the safety of Aria e prescribing system which is not available to staff in the ED and the patient risks associated with this.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

# Enforcement actions (s.29A Warning notice)

## Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

| Why there is a need for significant improvements | Where these improvements need to happen |
|---|---|
| Start here... | Start here... |

# WEXHAM PARK HOSPITAL

## CQC Action Plan

as at February 2016

***Ragging Key:***

- Achieved/on target/progress made
- In progress but some challenges
- Significant difficulty, poor progress

**Wexham Park Hospital**
**CQC Action Plan**

| Site | Recommendation & Current Risk Rating | Actions | Target Completion Date | Director Lead | Manager | Monitoring Committee | Current Status |
|---|---|---|---|---|---|---|---|
| **Wexham** | The cleanliness of the hospital must be audited in line with standards set out in the national specifications for cleanliness in the NHS (NSC). This includes the correct classification of high risk and very high risk areas and the frequency of auditing in these areas. Audit process should include a re-audit where areas are found to be less than 100% compliant. If the hospital chooses not to audit to NSC (national specifications for cleanliness) standards they must provide evidence of an equally robust auditing programme | • The Trust currently audits against the national cleanliness standards and audits against the 49 elements. The Trust has set its own pass rates, but will now change these to fit in with the NSC (national specifications for cleanliness).<br>• PDAs will be introduced so that results can be disseminated to wards and managers. The Trust will set up a PLACE Committee and this committee will review audit results.<br>• The Trust will conduct a Trust wide audit of all policies relating to cleanliness to ensure they are relevant and up to date<br>• Re-training in the use of microfibre cleaning cloths will take place. | Achieved<br><br>April 2016<br><br>July 2016 | Director of HR & Corporate Services | Deputy Director of Estates & Facilities | PLACE Committee | • Cleanliness audit and new pass rate implemented |
| **Frimley Health** | Ensure that the Policy around Candour (DofC) includes incidents resulting in 'psychological harm'. The provider must also ensure the policy is followed when managing incidents that come under the regulation. | • Duty of Candour (DofC) Policy to be reviewed to include psychological damage and approved by Trust Board of Directors (BOD)<br>• Trust seeking expert advice from National Patient Safety team<br>• Policy to be further implemented and training plan to be developed including workshops by speciality for clinicians<br>• Incidence of DofC to be included in monthly Quality & Performance Report presented to BOD | April 16<br><br>March 2016<br><br>May 2016<br><br>April 2016 | Medical Director<br>Director of Nursing | Deputy Director of Nursing FPH | Quality Committee | • Principles of Duty of Candour currently included in mandatory patient safety training programme<br>• Quarterly audit of compliance with policy undertaken |

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| **Wexham** | Continue with its delivery and the risk priorities associated with the backlog programme. Fire risks associated with the backlog need to be addressed as a priority on the Wexham Park site | • The work on risk assessments on backlog maintenance and fire assessments continues. Priorities that have been identified will be addressed in line with the trust's Capital Programme. | Plan with priorities by 1/4/16 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Capital Planning Committee | |
| **Wexham** | Improve Estates governance and ensure that up to date and approved policies and standard operating procedures (SOP's) are in place | • The Trust is currently adopting Frimley Park Hospital policies, but these are in the process of review for Wexham Park. Some have been actioned and implemented already.<br>• A Compliance Manager has now been appointed and APs identified and are in the process of being trained.<br>• The Director of HR & Corporate Services has approved appointments on behalf of the Chief Executive<br>• Competent persons to be identified once APs are trained.<br>• A programme for identifying new policies for the Trust will be developed. 1.4.2016<br>• The Trust will use the premises assurance model as a check list for ensuring the correct policies and procedures are in place. | August 2016<br><br>Achieved<br><br>Achieved<br><br>August 2016 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Capital Planning Committee | Achieved January 2016<br><br>Achieved January 2016 |
| **Wexham** | Ensure that monitoring of weekly medicine stock checks in critical care is consistently applied and must ensure that the system in place to make sure out of date medicine is disposed of, is audited | • Review Critical Care guideline in relation to medicines management and provide refresher training within the Unit<br>• Review audit programme for medicines management including disposal of out of date medicines within the Critical Care Unit<br>• Re-audit end of February 2016 | March 2016 | Director of Ops (WPH) | Chief Pharmacist | Critical Care Clinical Governance Meeting | |

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| **Wexham** | Ensure that resuscitation equipment is always checked according to the Trust policy. The auditing system must include a visual check of the expiry of dates of batteries | • Audits of compliance now include a visual check of expiry dates | March 2016 | Director of Nursing | Lead Nurse for Deteriorating Patient & Resus | Resuscitation Committee | Achieved January 2016 |
| **Wexham** | Cleaning and storage materials in critical care must be stored in locked facilities and the lock for the cleaning cupboard must be replaced | • Review current provision<br>• Identify gap in provision<br>• Estates to undertake environmental works to ensure compliance including new lock to be fitted to cleaning cupboard | March 2016 | Director of Nursing | Head of Nursing – Surgery & Critical Care | Critical Care Governance Meeting | |
| **Wexham** | Recruit to the 3 vacant consultant posts in ED. Although consultant cover in ED had improved since our last inspection the department still fell short of national standards | • Approval received to recruit to 3 new ED consultant posts | December 2016 | Medical Director | Chief of Service ED | Corporate Governance | |
| **Wexham** | Ensure that all oxygen cylinders have an expiry date displayed and system in place for staff to check that cylinders are within date | • Formal Audit undertaken every year where all cylinders are located and checked in conjunction with BOC | March 2016 | Director of Ops (WPH) | Chief Pharmacist | Drugs & Therapeutics Committee | Arrangements made with BOC to undertake audit of cylinders at Wexham to their expiry dates, to be done by mid-March with report back to the Trust Medical Gas Committee meeting in April 2016. |

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|---|---|---|---|---|---|---|---|
| **Frimley Health** | Continue to improve staffing recruitment and retention | • The Trust has put in place a robust recruitment plan and this is monitored regularly by Directors and reported monthly to the Board. The Trust will continue to actively recruit and retain staff using all tools and resources possible.<br>• The HR department will continue to set and monitor targets for recruitment and retention. To maintain nurse recruitment target of 20 – 30 new starters each month<br>• Plans to recruit nurses from Philippines & Europe plus local students. Aiming to reduce vacancy rate from 20% to 15%<br>• Cross site Safe Staffing Matron appointment, currently on induction<br>• Next Staffing paper to BOD March 16 | January 2017 | Director of HR & Corporate Services / Director of Nursing | Deputy Director of Nursing (WPH) / Asst Director of Resourcing | Workforce Committee | |
| **Wexham** | Ensure all staff in outpatients have development opportunities and training as agreed in their personal development plans (PDP) (Refers to Radiology staff) | • Undertake review of training and development requirements across the Radiology department via PDPs<br>• Develop a schedule which allows time for individuals to be released to complete their training requirements<br>• Include key performance indicators within the Radiology Dashboard<br>• Continue with recruitment and retention initiatives within the Radiology Department | April 2016 | Director of Ops (WPH) | Head of Radiology | Quality Committee | |
| **Wexham** | Ensure that regular and routine checks are made of the temperature of medication fridges | • Regular checks in place and monitored through monthly peer review<br>• Peer review results incorporated onto the ward dashboards. | March2016 | Director of Nursing | Deputy Director of Nursing WPH / Heads of Nursing | Nursing & Midwifery Board | |

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| **Wexham** | Consider plans for an additional CT scanner and integrated x-ray within the new emergency centre development planned for 2016 | • Plans in development for second CT scanner within current Radiology Department<br>• Funding identified within the Medical Equipment budget<br>• Third CT scanner planned within the new Emergency Centre development | September 2016<br><br>In plan | Director of Ops (WPH) | Director of Diagnostics / Head of Radiology | Capital Planning Committee<br><br>CDIC | |
| **Wexham** | Improve Pharmacy support for the emergency department and decision unit (EDDU) in particular | • To review Pharmacy support in Emergency Department in line with national benchmarking and provide accordingly | March 2016 | Director of Ops (WPH) | Chief Pharmacist | Top Team | |
| **Wexham** | Explore an effective means of explaining to patients why they have to wait to be treated in the ED | • Clinical team to review most effective way of communicating with patients why they have to wait to be treated in Emergency Department – specific literature to be developed | April 2016 | Chief of Service ED | Deputy Chief of Service ED | ED Clinical Governance Committee | |
| **Wexham** | Consider testing the major incident plan which had recently been re-written | • Table-top exercise planned | March 2016 | Director of Ops (WPH) | Head of Emergency Planning | Resilience Committee | |
| **Wexham** | Consider the size and organisation of paper health records | • EDMS programme over the next 2 years within pilot specialities due to go live in June 2016<br>• Notes of active patients to be scanned into new system as required<br>• Culling of static notes to commence2017<br>• Ordering of notes agreed by Clinical Reference Group | EDMS programme to commence June 2016 | Director of Ops (WPH) | Head of Nursing and General Manager Outpatients | EDMS Programme Board | |
| **Wexham** | Ensure the audit trail of medications delivered to wards is completed including the signature of the staff member receiving the medications on the ward | • Undertake rolling audit programme across all wards in relation to dispatch to receipt process of medications from Pharmacy to ward<br>• Training and on-going monitoring tool to be developed based on audit results | May 2016 | Director of Ops (WPH) | Chief Pharmacist | Quality Committee | |

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| **Wexham** | Consider the safety of Aria a prescribing system which is not available to staff in the ED and the patient risks associated with this | • Explore feasibility of providing access to Aria for Emergency Department via National Aria User Group<br>• Reinforce with Emergency Department who to contact for information on a patient's chemotherapy course. This information is available through Eden Day Unit & Eden Ward out-of-hours. | March 2016<br><br>February 2016 | Director of Ops (WPH) | Chief Pharmacist | | |
| **King Edward VII** | Ensure that the temperatures are monitored in areas where chemotherapy medicines are stored | • Regular checks in place and monitored through monthly peer review<br>• Peer review results incorporated onto Ward dashboards<br>• Air conditioning to be installed | February 2016<br><br>March 2106 | Director of Nursing | Head of Nursing Medicine | Oncology & Haematology Clinical Governance | |
| **King Edward VII** | Ensure that patients and staff are able to use emergency calls bells in all toilet cubicles | • Patient toilets had been changed for use by staff. These have now been reverted to Patient use with emergency call bells available in all toilet cubicles | Achieved | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Capital planning committee | Achieved January 2016 |
| **King Edward VII** | Consider making improvements to the temperature in the patient toilet areas | • The Trust will ask the owners of the building whether this is possible. | March 2016 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Outpatient Clinical Governance | |
| **King Edward VII** | Ensure that the environment allows for patients to have privacy where required during their care and treatment | • The Trust will remind the owners of the building of the need to ensure patient privacy.<br>• The Trust will consider whether a regular Users Meeting with the owners of the building is possible thus enabling users to bring to attention any concerns that they have with the environment.<br>• Explore other options to be able to access alternative rooms | March 2016 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Outpatient Clinical Governance | A regular users meeting has been set up with the first meeting due on 26/02/16 |
| **King Edward VII** | Consider the size and layout of paper health records to ensure that documents can be located easily | • Reinforce the need to create a second volume when medical records exceed agreed standard<br>• Trust plans to implement EDMS and has a project plan in place for the roll out | February 2016<br><br>Commences June 2016 | Director of Ops (WPH) | Head of Nursing and General Manager Outpatients | EDMS Programme Board | |

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|---|---|---|---|---|---|---|---|
| **King Edward VII** | Make improvements to emergency department staff being able to access the electronic prescribing system used for patients requiring chemotherapy. Although staff had put measures to mitigate the risk, the Trust may wish to reassess the risks associated with these measures | • Explore feasibility of providing access to Aria for Emergency Department via National Aria User Group<br>• Reinforce with Emergency Department who to contact for information on a patient's chemotherapy course | April 2016 | Director of Ops (WPH) | Chief Pharmacist | Oncology & Haematology Clinical Governance | |
| **King Edward VII** | Consider staffing numbers on the unit | • Review skills mix for Chemotherapy services | April 2016 | Director of Nursing | AD Medicine / Head of Nursing Medicine | Oncology & Haematology Clinical Governance | |

Frimley Health NHS
NHS Foundation Trust

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| Report Title | **Frimley Health NHS Foundation Trust Quality Improvement Plan – February 2016** |
| Agenda Number | 8. |
| Report type | To advise the Board of Directors on the progress against the Frimley Health NHS Foundation Quality Improvement Plan as agreed at the first meeting of the new Trustwide Quality Committee |
| Prepared by | Debbie Barrow<br>Governance Manager – Nursing & Quality |
| Executive Lead | Dr T Ho – Medical Director |
| Executive Summary | Attached is the newly developed Frimley Health Quality Improvement Plan which was reviewed and agreed at the first meeting of the Trustwide Quality Committee in February 2016.<br><br>**Section 1** (pages 3 – 9) describes the recommendations arising from the CQC Report from the Wexham Park Hospital Inspection in October 2015 and the actions being taken by the Trust to address these.<br><br>**Section 2** (paged 9 – 13) describes the outstanding key quality and patient safety risks from the previous HWPH and FPH individual Quality Improvement Plans and the actions that are being taken to mitigate those risks, current work streams in progress and further work required. Progress against the Improvement Plan is monitored on a monthly basis by the Frimley Health Quality Committee. |
| Background | Since October 2014, the Trust has had two site-specific Quality Committees which have coordinated and monitored the implementation of the responsive actions being taken by the organisation in relation to quality and provides assurance to the Board that the quality agenda is being embedded in line with the quality strategy, and that performance is measured and monitored.<br><br>The Trust has now moved to having one, Trustwide Quality Committee and the first meeting was held in February 2016. |
| Recommendation | The Board of Directors is asked to review the progress against the action plan, to agree the priority areas of concern and trajectories for achieving compliance |
| Appendices | **Frimley Health NHS Foundation Trust Quality Improvement Plan – February 2016** |

# FRIMLEY HEALTH NHS FOUNDATION TRUST

## Quality Improvement Plan

as at February 2016

***Ragging Key:***

- → Achieved/on target/progress made
- → In progress but some challenges
- → Significant difficulty, poor progress

**Frimley Health Quality Improvement Plan**
**As at February 2016**

## SECTION ONE – Response to recommendations from CQC Report following Wexham Park Hospital inspection

| Site | Recommendation & Current Risk Rating | Actions | Target Completion Date | Director Lead | Manager | Monitoring Committee | Current Status |
|---|---|---|---|---|---|---|---|
| **Wexham** | The cleanliness of the hospital must be audited in line with standards set out in the national specifications for cleanliness in the NHS (NSC). This includes the correct classification of high risk and very high risk areas and the frequency of auditing in these areas. Audit process should include a re-audit where areas are found to be less than 100% compliant. If the hospital chooses not to audit to NSC (national specifications for cleanliness) standards they must provide evidence of an equally robust auditing programme | • The Trust currently audits against the national cleanliness standards and audits against the 49 elements. The Trust has set its own pass rates, but will now change these to fit in with the NSC (national specifications for cleanliness).<br>• PDAs will be introduced so that results can be disseminated to wards and managers. The Trust will set up a PLACE Committee and this committee will review audit results.<br>• The Trust will conduct a Trust wide audit of all policies relating to cleanliness to ensure they are relevant and up to date<br>• Re-training in the use of microfibre cleaning cloths will take place. | Achieved<br><br>April 2016<br><br>July 2016 | Director of HR & Corporate Services | Deputy Director of Estates & Facilities | PLACE Committee | • Cleanliness audit and new pass rate implemented |

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| **Frimley Health** | Ensure that the Policy around Candour (DofC) includes incidents resulting in 'psychological harm'. The provider must also ensure the policy is followed when managing incidents that come under the regulation. | • Duty of Candour (DofC) Policy to be reviewed to include psychological damage and approved by Trust Board of Directors (BOD)<br>• Trust seeking expert advice from National Patient Safety team<br>• Policy to be further implemented and training plan to be developed including workshops by speciality for clinicians<br>• Incidence of DofC to be included in monthly Quality & Performance Report presented to BOD | April 16<br><br>March 2016<br><br>May 2016<br><br>April 2016 | Medical Director Director of Nursing | Deputy Director of Nursing FPH | Quality Committee | • Principles of Duty of Candour currently included in mandatory patient safety training programme<br>• Quarterly audit of compliance with policy undertaken |
| **Wexham** | Continue with its delivery and the risk priorities associated with the backlog programme. Fire risks associated with the backlog need to be addressed as a priority on the Wexham Park site | • The work on risk assessments on backlog maintenance and fire assessments continues. Priorities that have been identified will be addressed in line with the trust's Capital Programme. | Plan with priorities by 1/4/16 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Capital Planning Committee | |
| **Wexham** | Improve Estates governance and ensure that up to date and approved policies and standard operating procedures (SOP's) are in place | • The Trust is currently adopting Frimley Park Hospital policies, but these are in the process of review for Wexham Park. Some have been actioned and implemented already.<br>• A Compliance Manager has now been appointed and APs identified and are in the process of being trained.<br>• The Director of HR & Corporate Services has approved appointments on behalf of the Chief Executive<br>• Competent persons to be identified once APs are trained.<br>• A programme for identifying new policies for the Trust will be developed. 1.4.2016<br>• The Trust will use the premises assurance model as a check list for ensuring the correct policies and procedures are in place. | August 2016<br><br>Achieved<br><br>Achieved<br><br>August 2016 | Director of HR & Corporate Services | Deputy Director Estates & Facilities | Capital Planning Committee | Achieved January 2016<br><br>Achieved January 2016 |

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| **Wexham** | Ensure that monitoring of weekly medicine stock checks in critical care is consistently applied and must ensure that the system in place to make sure out of date medicine is disposed of, is audited | • Review Critical Care guideline in relation to medicines management and provide refresher training within the Unit<br>• Review audit programme for medicines management including disposal of out of date medicines within the Critical Care Unit<br>• Re-audit end of February 2016 | March 2016 | Director of Ops (WPH) | Chief Pharmacist | Critical Care Clinical Governance Meeting | |
| **Wexham** | Ensure that resuscitation equipment is always checked according to the Trust policy. The auditing system must include a visual check of the expiry of dates of batteries | • Audits of compliance now include a visual check of expiry dates | March 2016 | Director of Nursing | Lead Nurse for Deteriorating Patient & Resus | Resuscitation Committee | Achieved January 2016 |
| **Wexham** | Cleaning and storage materials in critical care must be stored in locked facilities and the lock for the cleaning cupboard must be replaced | • Review current provision<br>• Identify gap in provision<br>• Estates to undertake environmental works to ensure compliance including new lock to be fitted to cleaning cupboard | March 2016 | Director of Nursing | Head of Nursing – Surgery & Critical Care | Critical Care Governance Meeting | |
| **Wexham** | Recruit to the 3 vacant consultant posts in ED. Although consultant cover in ED had improved since our last inspection the department still fell short of national standards | • Approval received to recruit to 3 new ED consultant posts | December 2016 | Medical Director | Chief of Service ED | Corporate Governance | |
| **Wexham** | Ensure that all oxygen cylinders have an expiry date displayed and system in place for staff to check that cylinders are within date | • Formal Audit undertaken every year where all cylinders are located and checked in conjunction with BOC | March 2016 | Director of Ops (WPH) | Chief Pharmacist | Drugs & Therapeutics Committee | Arrangements made with BOC to undertake audit of cylinders at Wexham to their expiry dates, to be done by mid-March with report back to the Trust Medical Gas Committee meeting in April 2016. |

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| **Frimley Health** | Continue to improve staffing recruitment and retention | • The Trust has put in place a robust recruitment plan and this is monitored regularly by Directors and reported monthly to the Board. The Trust will continue to actively recruit and retain staff using all tools and resources possible.<br>• The HR department will continue to set and monitor targets for recruitment and retention. To maintain nurse recruitment target of 20 – 30 new starters each month<br>• Plans to recruit nurses from Philippines & Europe plus local students. Aiming to reduce vacancy rate from 20% to 15%<br>• Cross site Safe Staffing Matron appointment, currently on induction<br>• Next Staffing paper to BOD March 16 | January 2017 | Director of HR & Corporate Services / Director of Nursing | Deputy Director of Nursing (WPH) / Asst Director of Resourcing | Workforce Committee | |
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| **King Edward VII** | Consider staffing numbers on the unit | • Review skills mix for Chemotherapy services | April 2016 | Director of Nursing | AD Medicine / Head of Nursing Medicine | Oncology & Haematology Clinical Governance | |

## SECTION TWO – Quality Committee Quality Improvement Plan

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| **Frimley Health** | **Mandatory Training Data**<br>To consider mandatory training data available from Frimley & Wexham and amalgamate into one new system to avoid potential for inaccurate data and inability to provide evidence of compliance | • All statutory mandatory training records to be entered on OLM<br>• Reports issued to all Tier 2 leaders and to Tier 3 leaders as identified | July 2016 | Director of HR & Corporate Services / Director of Nursing | Deputy Director of Nursing (WPH) / Asst Director of Resourcing | Workforce Committee | |
| **Frimley Health** | **Medical Staffing Out of Hours / Use of Agency**<br>To ensure early identification of potential gaps in medical staffing cover out of hours and minimise the use of agency staff | • Medical Staffing Manager to meet with Chiefs of Service to provide assurance regarding process<br>• To establish a Medical Staffing working Group | February 2016<br><br>March 2016 | Medical Director | Deputy Medical Directors FPH & WPH | Workforce Committee | |

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| **Frimley Health** | **Deteriorating Patient:**<br>To ensure all clinical staff have the right skills & tools to recognise & deliver timely treatment to the deteriorating patient | • Cross-site Resuscitation Committee to establish work streams & agree strategy for delivery of policies & directives<br>• To implement national early warning score system across all 3 sites<br>• To undertake an annual Trustwide audit of deteriorating patient | February 2016<br><br>1 April 2016<br><br>July 2016 | Medical Director | Lead Nurse for Deteriorating Patient | Resuscitation Committee | Achieved February 2016 |
| **Frimley Health** | **Sepsis**<br>To agree, implement and reinforce the importance of Sepsis screening & administering antibiotics within the agreed timeframe. National Q4 target 90% | • Review, consider and agree screening tool to be used across Frimley Health<br>• Combined AKI & Sepsis Nurse being funded by Health Foundation for FPH<br>• Interim Sepsis Nurse lead in FPH ED in place Q4 | December 2015<br><br>May 2016<br><br>March 2016 | Medical Director | Lead Nurse for Deteriorating Patient<br><br>Head of Quality FPH | Quality Committee | Currently reviewing new national Sepsis Guidance Achieved |
| **Frimley Health** | **Acute Kidney Injury**<br>To reinforce the importance of early recognition and treatment of acute kidney injury. National Q4 target 90% | • To further embed AKI tool/bundle across Frimley Health. Q4 results April 2016<br>• Combined AKI & Sepsis Nurse being funded by Health Foundation for FPH<br>• Quality team undertaking on-going AKI audit, compliance results circulated to each speciality (FPH 84% January | April 2016<br><br>May 2016<br><br>Ongoing | Medical Director | Head of Quality FPH | Quality Committee | Achieved |
| **Frimley Health** | **Do Not Attempt Resuscitation**<br>To ensure there is evidence that DNAR decisions have been appropriately discussed & and are displayed in the medical records (at the front) | • To reinforce through education and awareness the importance of fully documenting DNAR decisions & demonstrate compliance through audit | July 2016 | Medical Director | | Resuscitation Committee | |
| **Frimley Park** | **Emergency Pressure / Bed Capacity**<br>To ensure quality of patient care through maximisation of bed capacity and patient flow | • Additional 42 beds opened at Farnham Hospital (Bourne & Hale Wards)<br>• New Matron for Cardiology & Stroke in post<br>• To fully recruit to Stroke Coordinator roles | January 2016<br><br>January 2016<br><br>April 2016 | Director of Operations | AD for Medicine | Unscheduled Care | Achieved (November 2014 & January 2016 Achieved January 2016 |

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| **Frimley Health** | **Discharge Planning**<br>To ensure there is a robust discharge planning process in place to reduce patients' length of stay, pressure on hospital beds and patient readmission | • Discharge planning is a Transformation Workstream supported by the Project Management Office (PMO), currently developing prioritised action plan with 'quick' wins and long term actions to be taken | March 2016 | Director of Nursing / Director of Operations | | Transformation Group Heads of Nursing | |
| **Frimley Health** | **Clinical Handover**<br>To ensure consistency in both medical and nursing handover arrangements & ownership | • Clinical Handover work stream under Sign up to Safety campaign, Trustwide launch 6th/7th January<br>• Clinical Handover for nurses redesigned and pilots implemented, findings of pilot to be evaluated<br>• 'Night into Day' medical handover to be reviewed<br>• To replicate WPH night medical handover model at FPH – looking at integrating surgeons into existing Medicine/Crit Care handover model. | January 2016<br>March 2016<br>March 2016<br>March 2016 | Medical / Nursing Directors | FPH DD of Nursing<br>FPH Deputy MD<br>ChOS Medicine & Surgery | Quality Committee | Achieved<br>400 staff engaged in event across FH<br>Meeting being arranged |
| **Frimley Health** | **Consent / Local Safety Standards for Interventional Procedures**<br>To ensure appropriate checking processes are in place for patients undergoing invasive procedures undertaken outside of Theatres | • Recommendations to be considered from national guidance NHS England Patient Safety Alert re: Supporting the introduction of the National Safety Standards for Invasive Procedures published, actions to be taken by September 2016<br>• Each speciality to identify NatSSIP lead<br>• Project lead appointed, to establish a small working group to scope work required, first meeting February 2016<br>• Review consent documentation and procedures & implement new process<br>• Review current patient information with particular focus on risks and benefits to support the consent process for high priority | September 2016<br>Achieved February 2016<br>September 2016<br>September 2016 | Medical Director / Director of Nursing | Deputy Medical Director (FPH) / Sign up to Safety Lead for Consent | | Initial review undertaken<br>Achieved February 2016 |

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| **Frimley Health** | **Perineum Damage**<br>To Improve care of the perineum during delivery to reduce the number of 3rd and 4th degree tears and to improve women's experience | • Develop teaching tool and education programme for all midwifery and obstetric staff of the management of the perineum during the second stage of labour<br>• Source perineal scissors that carry a marker to identify the correct angle of cut of a stretched perineum together with associated disposals and training aids<br>• Monitor LSCS rates to establish whether "hands on" practice reduces for subsequent births | January 2016<br><br>January 2016 | Director of Nursing | Adrienne Price | | Achieved<br><br>Achieved |

Frimley Health NHS
NHS Foundation Trust

# Quality and performance report

January 2016

Committed To Excellence | Working Together | Facing The Future

# Contents



**RAG key**

- Achieving target
- Between target and threshold (where applicable)
- Worse than target or threshold (where applicable)

# Executive summary

The report covers the period from January 2015 to allow comparison with historic performance. However the key messages and targets relate to January 2016 for the financial year 2015/16.

| Domain | |
|---|---|
| **Safe** | ▪ **Serious incidents requiring investigation (SIRI) -** There were six serious incidents requiring investigation reported in January for Frimley Health (four reported on the HWP site and two on the FPH site)<br>▪ **MRSA** - There was one MRSA bacteraemia reported for the trust in January (at HWP). This was agreed to have been "unavoidable" following a post-infection review |
| **Effective** | ▪ **Stroke** - A cardiovascular matron has started in post at FPH; we are starting to see the results of their input in performance. Performance at HWP has improved markedly<br>▪ **Mortality -** The summary hospital-level mortality indicator (SHMI) for elective and non-elective admissions remains as or better than expected |
| **Caring** | ▪ **Patient experience -** The trust maintains a high level of patients reporting that they are being treated with respect and dignity (97%), given enough privacy on the ward (97%) and have trust and confidence in doctors (94%)<br>▪ **Complaints -** The trust received a significant increase in complaints in January. This is potentially a reflection of the increased pressures on both sites |
| **Responsive** | ▪ **Diagnostic waits -** The trust reported that 0.6% (52) of patients did not receive their diagnostic test within the six weeks target, but this remained within the 1% national target for the third month in a row<br>▪ **Emergency department (ED) performance -** Frimley Health failed the 95% ED target for patients waiting to be seen, treated, admitted or discharged in less than four hours |
| **Workforce** | ▪ **Retention** - Trust-wide turnover has increased to 14.9% in January 2016, however the overall turnover rate at HWP has decreased<br>▪ **Recruitment** - Trust-wide vacancies decreased slightly in January; however vacancies still remain high across nursing and the allied health professional groups |
| **Efficiency & Finance** | ▪ **Average length of stay (LOS) -** There has been an improvement in both elective and non-elective average length of stay in hospital during this month.<br>▪ **Finance income** – Year to date operating income is £10.5m ahead of plan<br>▪ **Finance expenditure -** Operating expenditure is £10.7m over original plan year to date |

## Background context

GP referrals have increased by 4% when compared to the same time last year.

In January 2016 outpatient attendances have decreased by 2% when compared to the same month last year.

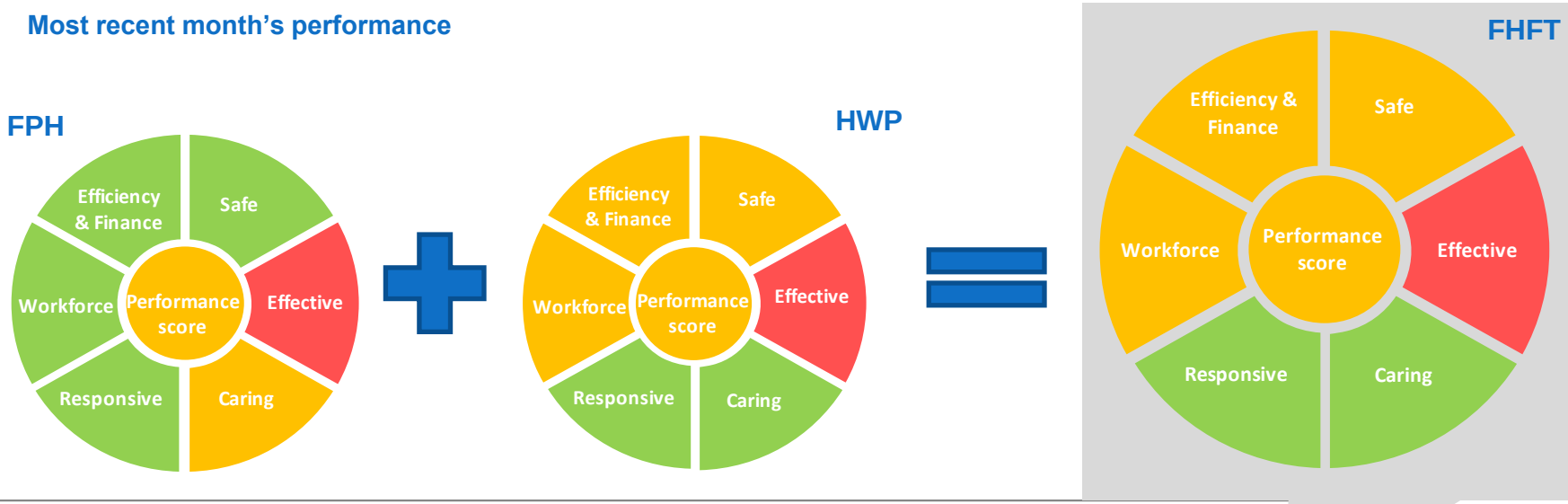
ED attendances have increased by 14% when compared to the same period last year.

Non-elective admissions in January 2016 were 8% up on the same period last year.

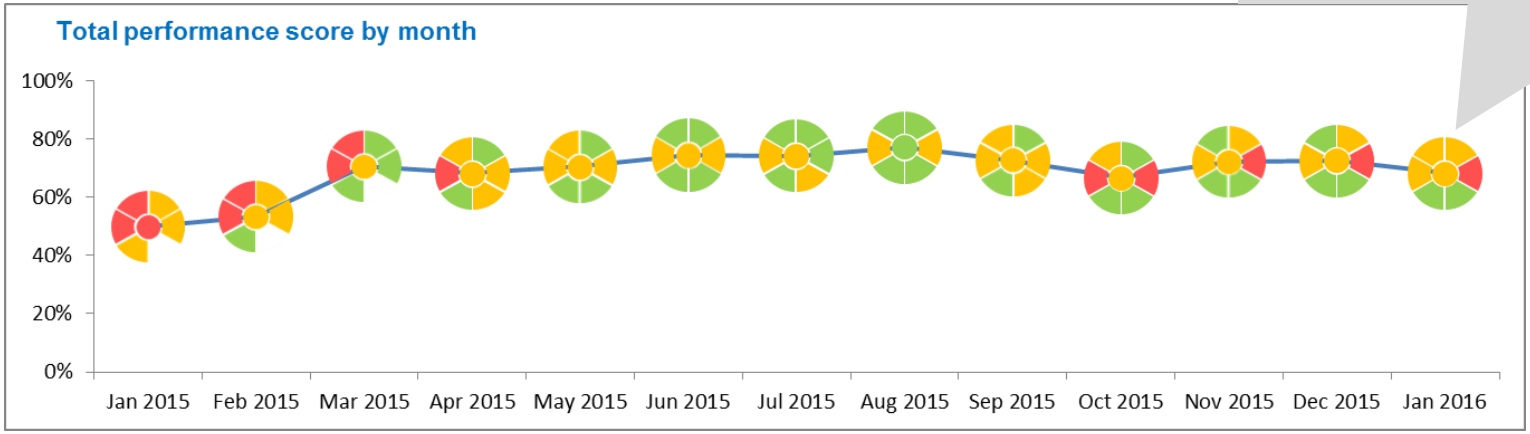
Elective admissions were down 1% in January 2016 when compared to January 2015.

# Performance summary

## Most recent month's performance




## Total performance score by month




***NOTES:*** *The "Caring" domain has only been scored from April 2015 onwards due to the large number of new measures from this date; the "Efficiency & Finance" domain is scored from Nov 2014 onwards post-acquisition; Finance is applied equally to both sites*

# Safe - Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Infection control** | ▪ There was one MRSA bacteraemia reported for Frimley Health in January (at HWP). This was agreed to have been "unavoidable" following a post-infection review<br>▪ There has been one C difficile case for Frimley Health in January (at HWP) | ▪ Formal root cause analysis (RCA) takes place for each trust apportioned MRSA bacteraemia and C difficile case<br>▪ Learning points from root cause analyses are included in the Infection Control Newsletters for the trust and in patient safety training |
| **Medication errors** | ▪ There were five low harm medication errors reported for Frimley Health in January (two on HWP site and three on FPH site) | ▪ Key reminders on how to prevent/reduce the risk of medication errors are included in the Patient Safety and Quality newsletters for the trust<br>▪ Discussions to highlight learning from incidents are conducted at the medications safety committee and key points are cascaded to clinical teams by the committee members |
| **Pressure ulcers** | ▪ There were nine grade 2 pressure ulcers reported in December for Frimley Health (five on HWP site and four on FPH site)<br>▪ Grade 2 pressure ulcer incidence remains below target for all sites<br>▪ There were no grade 3 or 4 pressure ulcers reported for Frimley Health during December (last reported month) | ▪ Education and awareness on prevention, grading and management of pressure ulcers continues |
| **Serious incidents requiring investigation** | ▪ There were six serious incidents requiring review (SIRI) reported in January for Frimley Health (four reported on the HWP site and two on the FPH site)<br>▪ Of the six SIRIs four were as a result of a fall, one related to an information governance breach and one to a clinical incident in the specialty of general surgery | ▪ Each incident will be subject to a root cause analysis (RCA)<br>▪ Key messages will be included in the Patient Safety and Quality newsletters to facilitate learning from incidents<br>▪ Patient safety training has been refreshed and aligned for teams on all sites and includes emotive patient/family stories of the impact of SIRIs to encourage teams to put safety at the forefront of care |
| **Harm Free Care (Safety Thermometer)** | ▪ 95% of patients were reported as having "harm-free" care in the safety thermometer audit for January | |
| **Falls** | ▪ There were five falls reported this month resulting in significant injury (three were on FPH site and two on WPH site) | ▪ Falls education and awareness continues across the trust<br>▪ Key messages will be included in the Patient Safety and Quality newsletters to help raise awareness on preventing falls |
| **Nurse staffing levels** | ▪ Overall Nurse staffing Compliance was 96% for Frimley Health | |

# Safe - Key measures

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | |
| Clostridium difficile * | 33 | 3 | 2 | 2 | 3 | 1 | 3 | 6 | 5 | 6 | 6 | 4 | 2 | 1 | 37 | None | None |
| Clostridium difficile due to lapses in care | 5 | 0 | 0 | 1 | 1 | 0 | 2 | 1 | 1 | 1 | 2 | 3 | 1 | 0 | 12 | <=31 | None |
| MRSA Bacteraemia | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 0 | None |
| **Medication errors resulting in harm** | | | | | | | | | | | | | | | | | |
| Low | 444 | 30 | 31 | 22 | 16 | 9 | 2 | 2 | 3 | 4 | 3 | 3 | 3 | 5 | 50 | None | |
| Moderate * | 47 | 3 | 1 | 5 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | <=42 | None |
| Severe * | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | None |
| **Pressure Ulcer Incidence** | | | | | | | | | | | | | | | | | |
| Hospital acquired - grade 2 * | 240 | 25 | 19 | 12 | 23 | 19 | 9 | 10 | 7 | 8 | 9 | 11 | 9 | in arrears | 105 | <=216 | None |
| Hospital acquired - grade 3 * | 18 | 2 | 1 | 1 | 0 | 3 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | in arrears | 6 | <=12 | None |
| Hospital acquired - grade 4 * | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | in arrears | 0 | 0 | None |
| **Harm-free care (safety thermometer)** | 95% | 96% | 96% | 96% | 95% | 94% | 95% | 96% | 95% | 95% | 96% | 96% | 94% | 95% | 95% | >=95% | <89% |
| **VTE risk assessment** | 97% | 98% | 98% | 98% | 98% | 99% | 99% | 99% | 99% | 98% | 98% | 98% | 97% | | 98% | >=95% | None |
| **Never Events** | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 5 | 0 | None |
| **Serious Incidents Requiring Investigation (SIRI) *** | 97 | 11 | 8 | 10 | 5 | 3 | 8 | 10 | 6 | 3 | 6 | 6 | 10 | 6 | 63 | <=90 | >8 |
| **Falls resulting in significant injury** | | | | | | | | | | | | | | | | | |
| Number of falls * | 41 | 5 | 2 | 3 | 2 | 2 | 3 | 2 | 0 | 1 | 3 | 4 | 3 | 5 | 25 | <=37 | None |
| Number of falls per 1000 bed days | 0.10 | 0.13 | 0.06 | 0.08 | 0.06 | 0.05 | 0.08 | 0.06 | 0.00 | 0.03 | 0.08 | 0.11 | 0.08 | 0.13 | 0.07 | TBC | |
| **Nurse Staffing - appropriate staffing levels** | | | | | | | | | | | | | | | | | |
| Medicine - overall staff | 99% | 99% | 100% | 100% | 102% | 96% | 99% | 101% | 98% | 100% | 99% | 98% | 96% | 97% | 99% | >=90% | None |
| Surgery - overall staff | 96% | 96% | 94% | 95% | 98% | 99% | 102% | 98% | 99% | 97% | 99% | 94% | 96% | 99% | 98% | >=90% | None |
| Medicine - registered staff | 98% | 99% | 100% | 100% | 101% | 94% | 97% | 99% | 95% | 97% | 97% | 97% | 94% | 96% | 97% | >=90% | None |
| Surgery - registered staff | 95% | 94% | 93% | 94% | 97% | 96% | 100% | 95% | 96% | 94% | 97% | 92% | 94% | 97% | 96% | >=90% | None |
| **National Safe Staffing Programme - as reported by NHS Choices (Compliance: planned number nursing hours versus actual)** | | | | | | | | | | | | | | | | | |
| Overall Compliance | | 99% | 98% | 99% | 99% | 96% | 100% | 98% | 96% | 98% | 98% | 97% | 94% | 96% | 97% | >=90% | None |

** Monthly targets are as follows: C. difficile (2);moderate medication errors (3); severe medication errors (0); Pressure ulcers grade 2 (18); grade 3 (1), grade 4 (0), SIRI (7);Falls (3)*

# Effective - Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Mortality** | ▪ The summary hospital-level mortality indicator (SHMI) for elective and non-elective admissions remains as or better than expected | ▪ Monitoring continues, including diagnostic groups, to direct investigation when required |
| **CRAB surgical complications** | ▪ This remains as or better than expected | ▪ A project has been planned to use CRAB reports to enhance the clinical coding and attribution accuracy |
| **CRAB medical practice triggers** | ▪ Acute kidney injury (AKI), shock/cardiac arrest and hospital acquired pneumonia (HAP) remain higher than normal<br>▪ The missed early warning score has reduced | ▪ The CQUINs for AKI and sepsis continue<br>▪ The "deteriorating patient" project exists on both sites<br>▪ A HAP prevention project is planned |
| **Stroke** | ▪ A cardiovascular matron has started in post at FPH; we are starting to see the results of their input in performance<br>▪ Performance at HWP has improved markedly | ▪ At FPH a new bed model has been developed and is pending implementation due to winter pressures<br>▪ At HWP the improved performance has been due to better ring-fencing of stroke beds more frequently throughout the month |
| **Cardiology** | ▪ The trust-wide cardiology "call to balloon" performance has improved to 95% for the most recent validated period of December and stands at 94% YTD, which is above the 85% target | |
| **Trauma & orthopaedics** | ▪ Trust-wide fractured neck of femur performance for January was 84% (80% at HWP and 92% at FPH). This is against a 90% target<br>▪ The key issues causing breaches continue to be around medication (specifically anticoagulants) and theatre time when a large number of patients with a fractured neck of femur present in one 24hr period | ▪ An orthogeriatric consultant has been appointed at the HWP site and is working within the orthopaedic team. An orthogeriatric consultant starts at FPH in the summer<br>▪ A consultation for trauma co-ordinators at both sites is underway to provide cover over the weekend and later into the evening |
| **Obstetrics** | ▪ Performance for the caesarean section rate (planned and unscheduled) is on trajectory for HWP, but slightly above trajectory at FPH due to the complexity of cases | ▪ On-going case by case reviews occur each month with the aim of reducing the number of planned caesarean sections |
| **Readmissions** | ▪ Emergency readmissions following an emergency admission have increased slightly | ▪ Specialties continue to review their readmission data. A new trust-wide readmissions report by specialty has been developed and circulated |

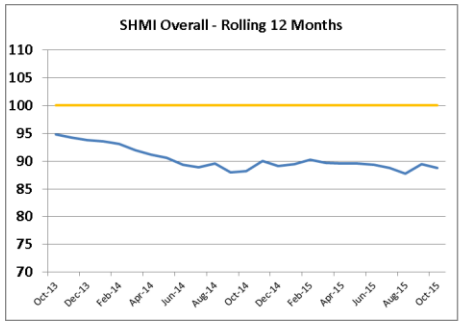
# Effective - Mortality trends (Summary hospital-level mortality indicator)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality (one month's data)** | | | | | | | | | | | | | | | | | |
| Number of deaths | 2470 | 272 | 222 | 230 | 201 | 204 | 179 | 185 | 171 | 209 | 189 | 213 | 234 | 203 | 1988 | | |
| Number of discharges | 199183 | 15927 | 15923 | 18307 | 16008 | 16264 | 17109 | 17732 | 15770 | 17440 | 17701 | 16973 | 17183 | 17425 | 169605 | | |
| % deaths | 1.2% | 1.7% | 1.4% | 1.3% | 1.3% | 1.3% | 1.0% | 1.0% | 1.1% | 1.2% | 1.1% | 1.3% | 1.4% | 1.2% | 1.2% | | |
| **SHMI (Summary hospital-level mortality indicator) (12 months' rolling data)** | | | | | | | | | | | | | | | | | |
| Overall observed number of deaths | | 3242 | 3292 | 3352 | 3396 | 3420 | 3427 | 3419 | 3433 | 3485 | 3457 | in arrears | in arrears | in arrears | | TBC | |
| Overall expected number of deaths | | 3489 | 3520 | 3601 | 3635 | 3663 | 3683 | 3704 | 3733 | 3757 | 3769 | in arrears | in arrears | in arrears | | TBC | |
| Overall SHMI rate | | 93 | 94 | 93 | 93 | 93 | 93 | 92 | 92 | 93 | 92 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Non-elective SHMI rate | | 93 | 93 | 93 | 93 | 93 | 93 | 92 | 92 | 93 | 92 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Elective SHMI rate | | 109 | 109 | 102 | 100 | 94 | 90 | 90 | 86 | 85 | 83 | in arrears | in arrears | in arrears | | <=100 | >125 |

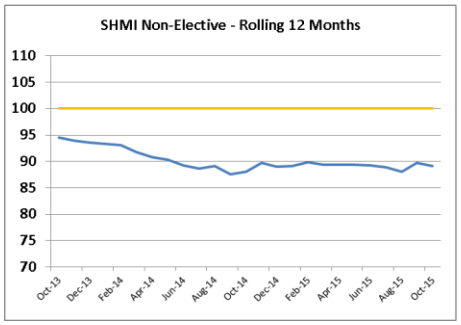
***KEY:*** Higher than expected | Within expected range | Lower than expected

**SHMI to Oct-15 (FPH)**

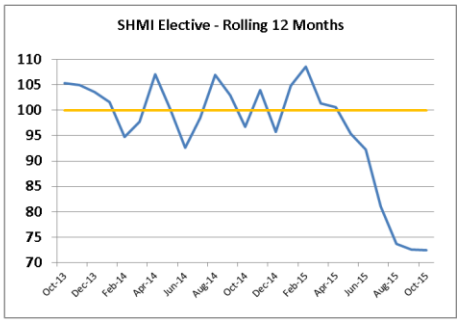
**Overall**



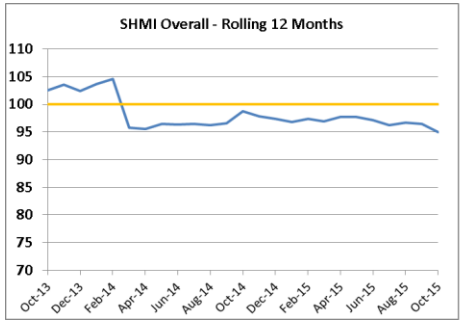

**Non-elective**

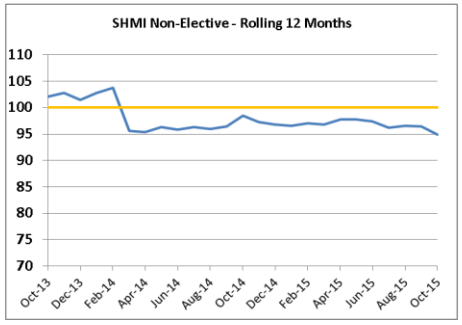


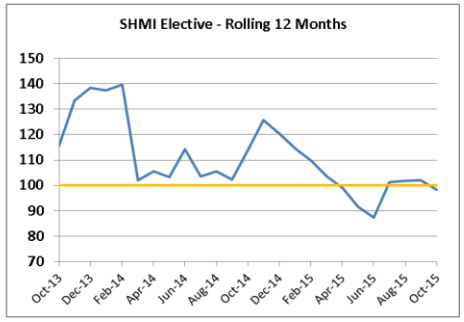

**Elective**




**SHMI to Oct-15 (HWP)**



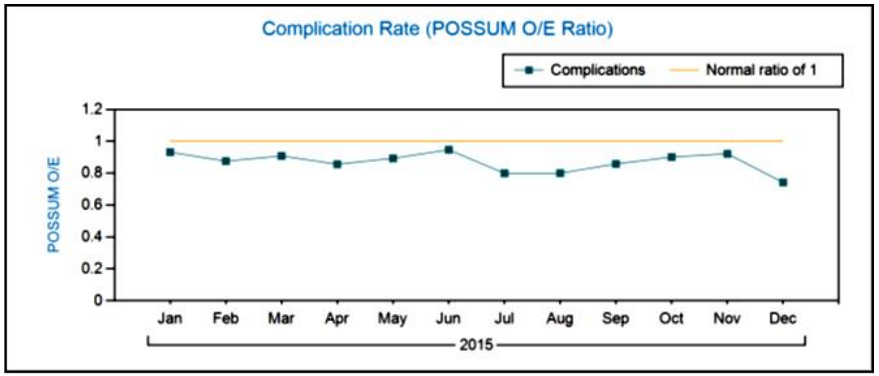



# Effective - CRAB surgical complications data

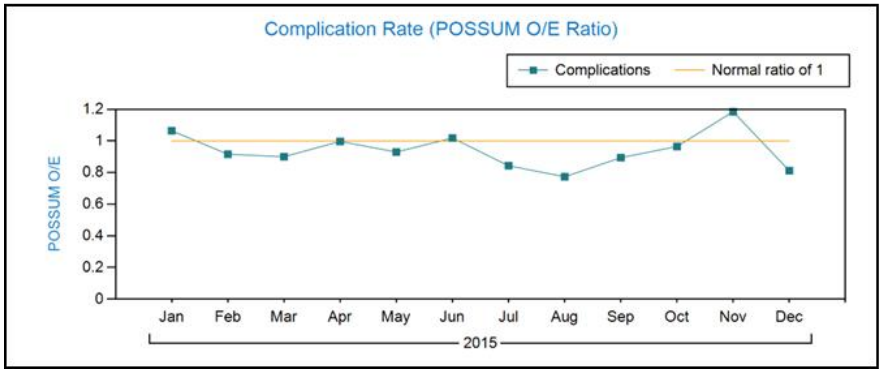
The trust has commissioned CRAB data which incorporates an assessment of each patient's risk of surgical complications and mortality based on coded data. A comparison of observed and expected rates can identify outcomes that are better than expected, as well as those that are worse. It can be used as a signal for concern, an improvement tool and as assurance to clinicians and others of the standard of care being provided.

- The surgical complication rates remain at or below expected at both sites

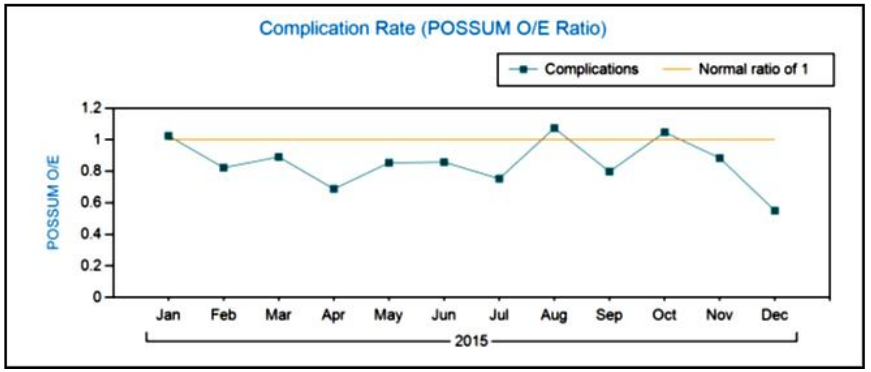
**Trust-wide**




**Frimley Park**




**Heatherwood & Wexham Park**



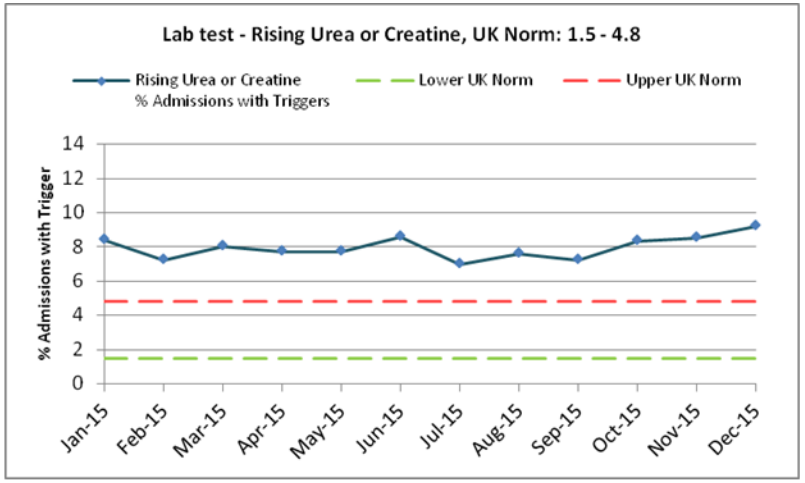
# Effective - CRAB medical practice trigger trends

CRAB demonstrates the quality of medical and ward care by estimating the incidence of key triggers. These are events during a patient's hospital admission which may have resulted from care-related harm. They are produced from coded data.

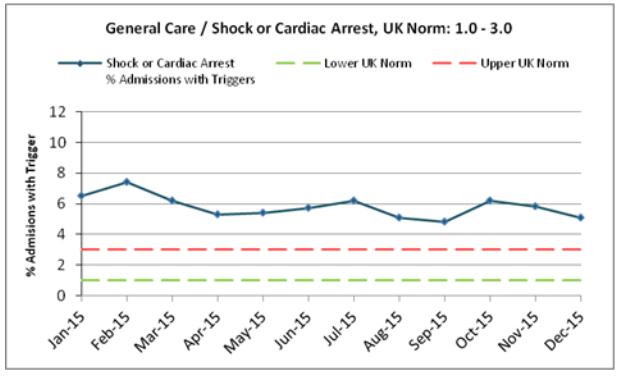
Trends are shown which will indicate potential problems for early investigation and also any response to Quality Improvement Interventions. A national normal range is shown on each graph. This slide shows trust-wide data.

- In medicine there is still a higher than "national normal" rate for acute kidney injury (AKI) (signalled by rising urea or creatinine), shock/cardiac arrest and nosocomial pneumonia (HAP) trust-wide
- AKI appears to be rising; the December cases are being examined
- Hospital acquired pneumonia (HAP) is lower than last winter but still high
- Missed early warning score has reduced and is within national norms
- "Deteriorating patient" initiatives are active on both sites
- The sepsis CQUIN is targeting early recognition and management of sepsis in the emergency department
- There is also a project aimed at improvement of documentation and coding of sepsis
- HAP diagnosis guidelines have being added to the microbiology app to reduce false diagnoses and over-treatment. A quality initiative project to reduce incidence is planned trust-wide
- The AKI CQUIN continues

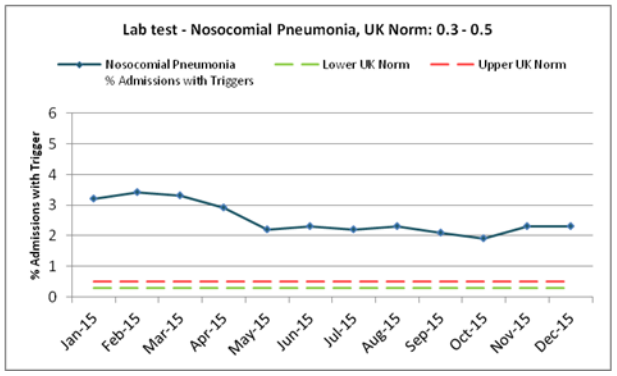
## Rising urea or creatinine



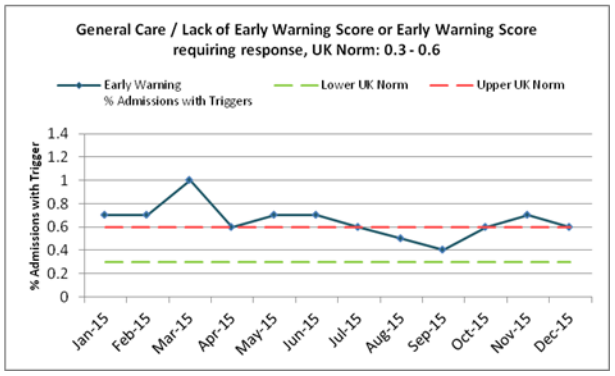

## Shock or cardiac arrest




## Nosocomial pneumonia




## Early warning



# Effective - Clinical performance measures

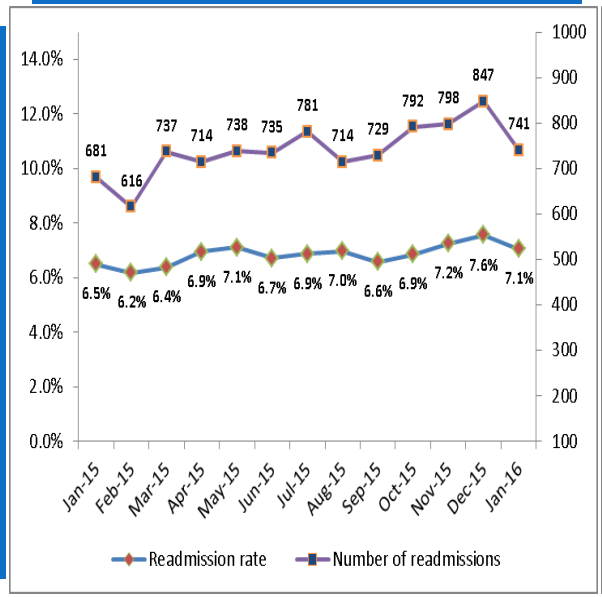
| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Stroke** | | | | | | | | | | | | | | | | | |
| % of patients admitted directly to the stroke unit in 4 hours | 71% | 68% | 50% | 78% | 69% | 71% | 65% | 75% | 69% | 68% | 62% | 67% | 54% | 63% | 66% | >=75% | <72% |
| **Cardiology** | | | | | | | | | | | | | | | | | |
| % of eligible patients receive treatment; call to balloon within 150 minutes | 90% | 90% | 100% | 95% | 86% | 91% | 88% | 100% | 96% | 100% | 100% | 86% | 95% | in arrears | 94% | >=85% | <80% |
| **Trauma and orthopaedics** | | | | | | | | | | | | | | | | | |
| % of patients who received surgery within 36 hours for a fractured neck of femur | 86% | 89% | 87% | 81% | 88% | 87% | 82% | 88% | 90% | 81% | 84% | 91% | 86% | 85% | 86% | >=90% | <80% |
| **Obstetrics** | | | | | | | | | | | | | | | | | |
| Caesarean section rate (planned & unscheduled) | 26% | 29.6% | 26.5% | 29.1% | 26.3% | 25.3% | 26.3% | 26.1% | 24.1% | 25.5% | 25.8% | 26.8% | 27.3% | 25.2% | 25.8% | <=23% | >26% |

# Effective – Emergency readmission trends

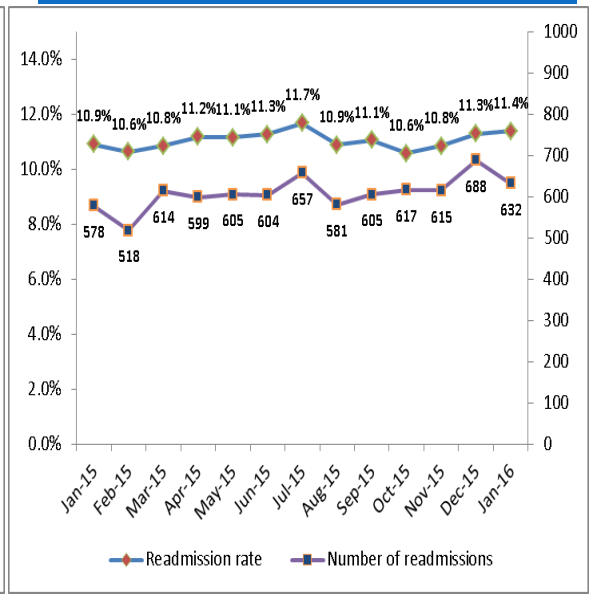
Lower readmission rates can be taken to indicate a higher quality service to patients as well as reducing costs for hospitals. The data is based on the number of patients who are readmitted to any specialty at either FPH or HWP within 30 days as an emergency following a previous elective or non-elective spell. The readmission spell must be an overnight stay.

Trust-wide

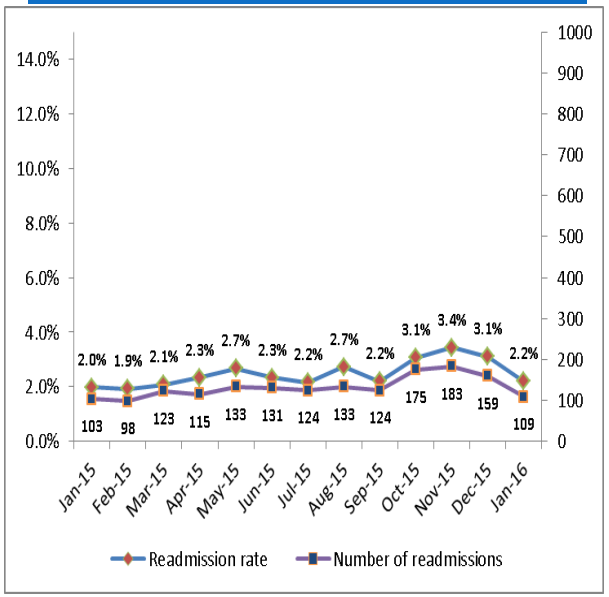
## Overall emergency readmissions




## Emergency readmissions following an emergency admission




## Emergency readmissions following an elective admission



# Caring - Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Patient experience** | ▪ The trust maintains a high level of patients reporting they are being treated with respect and dignity (97%), given enough privacy on the ward (97%) and have trust and confidence in doctors (94%) | ▪ Analysis of the qualitative comments received in quarter 3 has taken place and been shared with the heads of nursing and matrons for each directorate. These will encourage focus for the ward reviews and planning for priorities in 2016/17 |
| **Complaints** | ▪ The trust received 100% more complaints in January after the lowest number received YTD in December (35). This is potentially a reflection of the increased pressure on both main sites over December/January<br>▪ There has been an 11 percentage point improvement in the 25-day response rate whilst maintaining low numbers of reopened complaints | ▪ Further analysis will be undertaken to look for themes and address these as necessary through the patient experience forum |
| **Friends and family test (FFT)** | ▪ The trust has sustained an overall performance at 95% recommending the trust despite increasing operational pressure in January 2016 and this is a testament to the teams | ▪ Results of the friends and family tests are available to all wards, units and departments online<br>▪ Coding of qualitative comments is taking place to provide the areas with more meaningful data |
| **Planning for Discharge** | ▪ There has been a 24 percentage point increase in patients reporting that they have been involved in discharge planning with improvements demonstrated on both sites | ▪ There are a number of different groups working on improving discharge, including one focusing on patient experience |
| **Noise At Night** | ▪ Noise at night has shown an increase of 5 percentage points more patients reporting this. Noise from staff at night remains low | |

# Caring - Key measures

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Local Surveys (trust-wide measures are being reviewed; a new trust-wide survey will commence in 2015/16)** | | | | | | | | | | | | | | | | | |
| 1. Overall did you feel you were treated with respect and dignity whilst in hospital? | New | | | | 94% | 97% | 97% | 94% | 95% | 96% | 96% | 97% | 96% | 97% | 96% | >=90% | <80% |
| 2. Were you given enough privacy on the ward? | New | | | | 95% | 96% | 96% | 97% | 95% | 95% | 96% | 95% | 97% | 97% | 96% | >=90% | <80% |
| 3. Do you have confidence and trust in the doctors treating you? | New | | | | 90% | 92% | 92% | 94% | 91% | 92% | 92% | 91% | 93% | 94% | 92% | >=90% | <80% |
| 4. Were you bothered by noise at night from staff? (percentage of patients saying no) | New | | | | 84% | 86% | 88% | 90% | 88% | 87% | 88% | 87% | 88% | 86% | 87% | >=80% | <70% |
| 5. Were you bothered by noise at night from other patients? (percentage of patients saying no) | New | | | | 67% | 69% | 74% | 72% | 71% | 71% | 71% | 68% | 71% | 66% | 70% | >=75% | <65% |
| 6. Have you noticed a difference in the quality of your care at different times of the day or week? | New | | | | 92% | 87% | 89% | 92% | 90% | 89% | 90% | 89% | 93% | 91% | 90% | >=90% | <80% |
| 7. Do you get enough help from staff to eat your meals? | New | | | | 74% | 92% | 84% | 91% | 90% | 87% | 86% | 87% | 94% | 92% | 88% | >=90% | <80% |
| 8. Do you feel that you and your family/carers have been involved in planning for your discharge from hospital? | New | | | | 64% | 77% | 68% | 76% | 76% | 69% | 67% | 67% | 59% | 83% | 71% | >=75% | <65% |
| 9. Did staff examining and treating for you introduce themselves? | New | | | | 82% | 89% | 90% | 92% | 90% | 88% | 91% | 85% | 90% | 90% | 89% | >=90% | <80% |
| **Complaints** | | | | | | | | | | | | | | | | | |
| Number of complaints received * *** | 996 | 79 | 68 | 76 | 75 | 58 | 60 | 81 | 58 | 71 | 63 | 49 | 35 | 71 | 621 | <=68 | >75 |
| Number of complaints per 1000 bed days | 2.32 | 2.04 | 1.99 | 2.01 | 2.07 | 1.56 | 1.67 | 2.29 | 1.60 | 1.95 | 1.67 | 1.34 | 0.95 | 1.83 | 1.69 | <=1.90 | >2.10 |
| % of complaints answered within 25 days | 36% | 56% | 47% | 42% | 43% | 64% | 67% | 60% | 60% | 53% | 63% | 65% | 76% | in arrears | 60% | >85% | <70% |
| Number of complaints re-opened | 142 | | | 13 | 7 | 13 | 7 | 8 | 7 | 3 | 6 | 0 | 4 | 4 | 59 | TBC | |
| **Friends and Family Scores - What % would recommend this trust to friends and family if they needed similar care or treatment?** | | | | | | | | | | | | | | | | | |
| Overall % (includes inpatients, A&E, outpatients, maternity and community services) ** | 90% | 92% | 91% | 92% | 93% | 93% | 94% | 94% | 94% | 93% | 96% | 95% | 96% | 95% | 94% | >=90% | <85% |

** provisional data for the reporting month*
*** surveys include paediatrics and day surgery as from Apr-15 and community services from Jan-15*
**** Annual targets are as follows: Number of complaints (824)*

# Caring - What our patients are saying

## Some of the positive feedback we have received

"Absolutely superb care from both doctors and nurses"
**CCU, Frimley Park Hospital**

"So very caring - Radiographer so kind I cannot praise them highly enough - was very nervous - put me at ease."
**Radiology, Heatherwood Hospital**

"The staff here are very friendly and have well experiences. They manage to rebuild my confidence too."
**Amputee Therapy Service, Wexham Park Hospital**

## Where can we improve:

Comments have been fed back to the areas concerned immediately for action as required. Trends are reported to the Patient Experience Forum monthly

"I waited for a long time to be seen only to be told that there is nothing there can be done. A young doctor kept running in and out to talk to a senior member."
**Children's Clinic, Wexham Park Hospital**

"Had some confusing/conflicting information. Too many staff changes. Otherwise the staff were kind and caring. I am forever in their debt."
**F7, Frimley Park Hospital**

"Why give 12.30 appointment for all 6 people at same time?"
**Day Surgery Unit, Heatherwood Hospital**

# Responsive - Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Waiting lists** | ▪ The outpatient waiting list increased by over 700 patients<br>▪ The inpatient waiting list decreased slightly to 9152 | ▪ The trust will continue to review its demand and capacity across all specialties |
| **Diagnostic waits** | ▪ The trust reported that 0.6% (52) of patients did not receive their diagnostic test within the six weeks target, though this was within the 1% target for the third month in a row | |
| **Monitor Clostridium difficile** | ▪ For the financial year to date there have been 12 cases where lapses in care have been agreed during formal root cause analysis (RCA) (and one case is still pending RCA) | |
| **Monitor A&E** | ▪ Frimley Health failed the 95% emergency department (ED) target for patients waiting to be seen, treated, admitted or discharged in less than four hours | ▪ The trust will continue to try and improve the timely flow of patients from ED to the wards at both FPH and HWP |
| **Monitor RTT targets** | ▪ Frimley Health achieved the 92% incomplete referral to treatment (RTT) target within 18 weeks, with a performance of 92.3% | |
| **Monitor Cancer standards** | ▪ Overall cancer targets continue to be met, although there are challenges at present with a small number of patients diagnosed through screening. The number of patients on pathways longer than 104 days has shown a slight reduction; these patients are mainly at FPH where changes to tracking are being made in addition to the pathway work | ▪ Improvement project work continues on the failing specialities |

# Responsive - Responsive Key measures

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Waiting lists** | | | | | | | | | | | | | | | | |
| Outpatient Total Waiting List | | 15644 | 14942 | 15669 | 16376 | 17735 | 17509 | 18483 | 18624 | 18472 | 18821 | 17786 | 17581 | 18272 | None | |
| Elective Total Waiting List | | 7520 | 7522 | 7243 | 7544 | 7714 | 7869 | 7890 | 8050 | 8224 | 8434 | 8992 | 9197 | 9152 | None | |
| **Diagnostics** | | | | | | | | | | | | | | | | |
| Diagnostics waiting 6 weeks and over | 3479 | 671 | 451 | 150 | 247 | 425 | 518 | 464 | 455 | 346 | 162 | 37 | 47 | 52 | None | |
| % waiting over 6 weeks and over for a diagnostic | 3.3% | 7.3% | 4.9% | 1.7% | 2.8% | 4.3% | 5.5% | 5.3% | 5.6% | 4.2% | 2.0% | 0.4% | 0.5% | 0.6% | <=1.0% | None |
| **Referral to treatment (RTT)** | | | | | | | | | | | | | | | | |
| RTT Total incomplete waiting list | | 24663 | 24697 | 25060 | 25717 | 26914 | 26793 | 27569 | 27668 | 28340 | 29074 | 29144 | 29508 | 30733 | *Targets and thresholds to be agreed in light of new RTT guidance* | |
| RTT waiting 18 weeks and over (backlog) | | 1758 | 1790 | 1558 | 1413 | 1302 | 1418 | 1684 | 2027 | 2039 | 2023 | 2047 | 2300 | 2368 | | |
| RTT waiting 35 weeks and over | | 70 | 72 | 60 | 65 | 52 | 48 | 49 | 43 | 37 | 43 | 52 | 66 | 76 | | |
| RTT waiting 52 weeks and over | | 0 | 0 | 3 | 5 | 2 | 3 | 2 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | |

# Responsive - Monitor dashboard

| | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target | Weighting |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clostridium difficile** | | | | | | | | | | | | | | | | | | | |
| Total Clostridium difficile cases | 3 | 2 | 2 | 7 | 3 | 1 | 3 | 7 | 6 | 5 | 6 | 17 | 6 | 4 | 2 | 12 | 1 | | |
| Clostridium difficile due to lapses in care | 0 | 0 | 1 | 1 | 1 | 0 | 2 | 3 | 1 | 1 | 1 | 3 | 2 | 3 | 1 | 6 | 0 | 31 | 1.0 |
| **A&E** | | | | | | | | | | | | | | | | | | | |
| % admitted or discharged within 4 hours | 90.8% | 95.8% | 95.2% | 93.8% | 95.7% | 96.4% | 96.8% | 96.2% | 96.7% | 95.7% | 93.7% | 95.4% | 94.8% | 96.0% | 96.1% | 95.6% | 92.3% | >=95% | 1.0 |
| **RTT Waiting Times *** | | | | | | | | | | | | | | | | | | | |
| % treated within 18wks – admitted | 90.6% | 90.1% | 86.7% | 86.7% | 91.3% | 91.9% | 91.1% | 91.4% | 88.1% | 84.7% | 81.6% | 81.6% | 78.6% | 78.5% | 82.5% | 78.5% | 76.9% | >=90% | 1.0 |
| % treated within 18wks – non-admitted | 95.4% | 95.4% | 95.5% | 95.4% | 95.4% | 95.5% | 95.3% | 95.4% | 95.2% | 92.5% | 89.4% | 89.4% | 88.8% | 89.0% | 89.6% | 88.8% | 86.9% | >=95% | 1.0 |
| % waiting within 18wks - incomplete pathways | 93.7% | 93.5% | 94.4% | 93.9% | 94.5% | 95.2% | 94.6% | 94.8% | 94.3% | 92.7% | 92.8% | 93.2% | 93.0% | 93.0% | 92.2% | 92.7% | 92.3% | >=92% | 1.0 |
| **Cancer** | | | | | | | | | | | | | | | | | | | |
| 2 week waits – urgent GP referrals | 94.1% | 96.1% | 95.9% | 95.5% | 93.1% | 95.6% | 95.9% | 94.9% | 94.8% | 95.4% | 94.1% | 94.6% | 95.2% | 96.3% | 95.9% | 95.8% | in arrears | >=93% | 1.0 |
| 2 week waits - Breast symptomatic referrals | 97.1% | 99.0% | 99.5% | 98.7% | 96.9% | 97.7% | 97.2% | 97.2% | 97.4% | 93.4% | 93.0% | 94.4% | 97.7% | 93.9% | 97.3% | 96.2% | in arrears | >=93% | |
| 31 day wait for first treatment | 99.5% | 100% | 99.1% | 99.5% | 99.6% | 98.5% | 99.1% | 99.2% | 99.2% | 98.9% | 99.6% | 99.3% | 99.5% | 100% | 99.1% | 99.6% | in arrears | >=96% | 1.0 |
| 31 day wait for second or subsequent treatment – Surgery | 100% | 98.0% | 97.5% | 98.4% | 100% | 100% | 97.4% | 99.0% | 100% | 94.3% | 100% | 100% | 100% | 100% | 96.4% | 99.1% | in arrears | >=94% | 1.0 |
| 31 day wait for second or subsequent treatment – Anti-cancer drugs | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.0% | 100.0% | in arrears | >=98% | |
| 62 day wait for first treatment | 83.5% | 89.0% | 86.4% | 86.0% | 88.2% | 85.9% | 92.1% | 88.9% | 87.7% | 92.3% | 85.6% | 88.2% | 86.5% | 86.4% | 92.7% | 88.5% | in arrears | >=85% | 1.0 |
| 62 day wait for screening patients | 77.8% | 92.3% | 95.1% | 88.9% | 100% | 95.7% | 97.4% | 97.0% | 100% | 100% | 100% | 100% | 100% | 100% | 95.8% | 98.4% | in arrears | >=90% | |
| **Overall performance** | | | | | | | | | | | | | | | | | | | |
| Service performance score | | | | 3 | | | | 0 | | | | 0 | | | | 0 | | | |

** RTT Waiting Times (Admitted and Non-Admitted) are not RAG rated and not included in scoring from Jul-15 onwards as these are no longer national targets*

# Responsive – Cancer 62-day waits standard by tumour group

| | Dec-14 | Q3 | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain/CNS | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| Breast | 94.7% | 94.9% (64.5/68) | 100% | 100% | 100% | 100% (67/67) | 100% | 100% | 98.6% | 99.2% (63/63.5) | 100% | 100% | 100% | 100% (80/80) | 100% | 90.0% | 100% | 97.1% (67/69) | | |
| Childrens | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| Gynaecological | 82.4% | 61.1% (11/18) | 20.0% | 80.0% | 76.9% | 70.0% (10.5/15) | 66.7% | 75.0% | 100% | 76.5% (6.5/8.5) | 70.0% | 91.7% | 42.9% | 72.4% (10.5/14.5) | 88.2% | 83.3% | 83.3% | 85.7% (12/14) | | |
| Haematological | 75.0% | 81.3% (13/16) | 62.5% | 80.0% | 69.2% | 65.9% (13.5/20.5) | 100% | 100% | 66.7% | 85.7% (6/7) | 62.5% | 76.9% | 71.4% | 69.8% (15/21.5) | 63.2% | 54.5% | 100% | 67.9% (18/26.5) | | |
| Head & Neck | 60.0% | 69.6% (8/11.5) | 100% | 50.0% | 0.0% | 27.3% (1.5/5.5) | 83.3% | 57.1% | 80.0% | 72.2% (6.5/9) | 100% | 62.5% | 25.0% | 60.0% (4.5/7.5) | 33.3% | 55.6% | 40.0% | 47.1% (4/8.5) | | |
| Lower GI | 91.7% | 84.1% (26.5/31.5) | 88.0% | 93.3% | 96.2% | 92.4% (30.5/33) | 88.9% | 88.5% | 96.0% | 91.3% (31.5/34.5) | 100% | 90.9% | 80.0% | 94.1% (24/25.5) | 89.7% | 82.4% | 87.0% | 86.6% (29/33.5) | | |
| Lung | 100% | 88.5% (11.5/13) | 100% | 71.4% | 81.8% | 84.0% (10.5/12/5) | 100% | 60.0% | 83.3% | 78.3% (9/11.5) | 82.4% | 100% | 70.0% | 81.3% (19.5/24.5) | 75.0% | 92.3% | 100% | 84.6% (16.5/19.5) | in arrears | >=85% |
| Sarcomas | NA | NA | NA | 50.0% | 75.0% | 71.4% (2.5/3.5) | NA | NA | 100% | 100% (0.5/0.5) | NA | NA | NA | NA | 100% | NA | NA | 100% (1/1) | | |
| Skin | 100% | 98.0% (49.5/50.5) | 100% | 100% | 95.8% | 98.2% (54/550 | 100% | 100% | 92.6% | 97.2% (68.5/70.5) | 100% | 100% | 100% | 99.4% (82/82.5) | 100% | 96.8% | 100% | 98.8% (79.5/80.5) | | |
| Upper GI | 100% | 83.8% (15.5/18.5) | 60.0% | 88.9% | 93.3% | 82.4% (14/17) | 68.4% | 80.0% | 87.5% | 81.3% (19.5/24) | 90.9% | 70.0% | 50.0% | 79.3% (11.5/14.5) | 73.3% | 100% | 90.9% | 84.8% (14/16.5) | | |
| Urological | 72.7% | 73.0% (54/74) | 71.4% | 82.1% | 69.4% | 74.4% (43.5/58.5) | 81.0% | 80.0% | 85.7% | 80.6% (75/93) | 66.7% | 90.6% | 77.6% | 75.7% (54.5/72) | 77.3% | 86.7% | 85.7% | 84.1% (63.5/75.5) | | |
| Other | 0.0% | 0.0% (0/1.5) | 50.0% | NA | 100% | 66.7% (1/1.5) | 100% | NA | 100% | 100% (2/2) | NA | NA | 100% | 100% (2/2) | NA | 100% | 100% | 100% (3.5/3.5) | | |
| Total | **84.4%** | **83.8% (253.5/302.5)** | **83.5%** | **89.0%** | **86.4%** | **86.0% (246/285.5)** | **88.2%** | **85.9%** | **92.1%** | **88.9% (287.5/323.5)** | **87.7%** | **92.3%** | **85.6%** | **88.2% (303.5/344)** | **86.5%** | **86.4%** | **92.7%** | **88.5% (307/347)** | | |
| **Cancer – 62-day referral to treatment standard – over 104 day waiters** | | | | | | | | | | | | | | | | | | | | |
| Number of patients waiting over 104 days | | | | | | | | | | | 15 | 17 | 18 | | 15 | 16 | 21 | | 13 | |
| % of patients waiting over 104 days | | | | | | | | | | | 1.1% | 1.1% | 1.4% | | 1.2% | 1.2% | 1.7% | | 1.2% | |

*Half numbers are where a patient has been referred here for treatment from another provider or vice versa; the patient is shared between providers*
*The additional figures provided for the quarters are the number of patients treated within the 62-day standard out of the total number of patients treated for that tumour group*

# Workforce – Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Retention** | ▪ Trust-wide turnover has increased to 14.9% in January 2016, however overall turnover rate at HWP has decreased<br>▪ There was an increase in the number of new starters in January following a large intake of overseas and student nurses<br>▪ There is slight increase in leavers as compared to last month | ▪ Retention initiatives such as recruitment and retention premias (RRPs) and similar allowances are being reviewed across the trust to measure effectiveness and ensure consistency across all sites |
| **Recruitment** | ▪ Trust-wide vacancies decreased slightly in January; however vacancies still remain high across nursing and the allied health professional groups<br>▪ Overseas nursing recruitment continues, although external pressures (IELTS / NMC registration) are still proving a challenge to candidates starting with the trust<br>▪ The TRAC recruitment system was launched in January and is now used across the Trust. Paper-based processes are being replaced by the new system. "Time to hire" and key performance indicator (KPI) reports will become available over the coming months | ▪ HR are currently reviewing the recruitment process and looking to streamline the systems and forms used across all sites; to include enhanced recruitment reporting and the implementation of a new recruitment tracking system<br>▪ A new trust website has been launched, with careers information currently being updated to be included<br>▪ The "refer a friend scheme" has been launched for nursing and is being rolled out to other hard-to-recruit groups |
| **Temporary Staffing** | ▪ Agency spend has increased across the doctors and "other" staff groups. There is a slight reduction in nursing agency spend<br>▪ The second tier of the Monitor price caps was introduced on 1st February. Work is on-going with agencies to comply with these rules | ▪ The temporary staffing policy has now been approved by the executive board; communications will be sent out advising of the change<br>▪ HR have been communicating with all agencies following the introduction of the Monitor price caps in order to comply with the new rules – this is still on-going |
| **Sickness** | ▪ Monthly sickness absence has decreased to 3% this month<br>▪ Sickness rates are particularly high across additional clinical services (ie HCAs), estates & ancillary and healthcare science staff<br>▪ The highest amount of sickness continues to be due to "other musculoskeletal" and "anxiety, stress and depression"<br>▪ A new sickness reporting process has been rolled out for all staff groups not currently using eRostering | ▪ Sickness absence reports continue to be provided to HR business partners and directorates on a monthly basis<br>▪ A new trust-wide sickness absence policy is now in place<br>▪ A new sickness reporting process has been developed following the audit of medical sickness reporting and this has been communicated to all trust managers |
| **Appraisal** | ▪ Appraisal rates have increased by 2% this month<br>▪ Appraisal trackers are live on the file sharing portal. Compliance rates are expected to increase as information is backdated into the trackers | ▪ Training has been completed with 64 data entry people across the trust who are now able to update the trackers |
| **Statutory & Mandatory Training** | ▪ A single compliance figure is currently not possible due to issues surrounding reporting through WIRED<br>▪ Work is currently being undertaken to upload competence requirements into ESR in order to use this for reporting going forward | ▪ A paper has been submitted to HEB, the Quality Committee and CQC Steering Group regarding the issues and outlining the plan to resolve the issues |

# Workforce – Key measures

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff numbers** | | | | | | | | | | | | | | | | | |
| Staff in Post FTE | N/A | 7499 | 7496 | 7492 | 7473 | 7473 | 7494 | 7502 | 7470 | 7497 | 7530 | 7523 | 7512 | 7540 | N/A | N/A | N/A |
| Vacancy FTE | N/A | 666 | 674 | 685 | 960 | 965 | 955 | 946 | 955 | 943 | 952 | 963 | 993 | 988 | N/A | N/A | N/A |
| Starters FTE | 1124 | 110 | 77 | 90 | 82 | 78 | 87 | 86 | 78 | 127 | 150 | 94 | 65 | 109 | 955 | N/A | N/A |
| Leavers FTE | 1144 | 86 | 70 | 121 | 100 | 82 | 70 | 100 | 85 | 126 | 112 | 102 | 87 | 91 | 958 | N/A | N/A |
| **Turnover rates** | | | | | | | | | | | | | | | | | |
| Turnover % | 15.4% | 15.5% | 15.4% | 15.4% | 15.3% | 15.4% | 15.1% | 15.2% | 14.5% | 14.4% | 14.7% | 14.5% | 14.4% | 14.9% | 14.8% | 14.5% | 16.0% |
| Nursing Turnover % | 18.2% | 17.7% | 18.1% | 18.2% | 18.0% | 17.8% | 17.2% | 17.0% | 17.0% | 17.1% | 17.0% | 16.8% | 16.5% | 16.3% | 17.2% | <=16.0% | >17.5% |
| **Vacancy rate **** | | | | | | | | | | | | | | | | | |
| Vacancy % | N/A | 9.2% | 9.3% | 8.6% | 12.0% | 12.0% | 11.9% | 11.8% | 11.9% | 11.7% | 11.8% | 11.9% | 12.2% | 12.1% | N/A | <=11.75% | >13.25% |
| **Agency spend** | | | | | | | | | | | | | | | | | |
| Agency Spend as % of Pay Bill | 10.8% | 11.9% | 11.9% | 16.9% | 10.5% | 9.3% | 8.1% | 10.8% | 10.1% | 11.0% | 10.2% | 10.0% | 9.2% | 9.7% | 9.9% | <=8.0% | >10.0% |
| Agency - Doctors (£000s) | 17375 | 1573 | 1695 | 2833 | 1561 | 1314 | 997 | 1652 | 1296 | 1445 | 1236 | 1149 | 1110 | 1199 | 12959 | TBC | TBC |
| Agency - Nurses (£000s) | 13534 | 1465 | 1310 | 1766 | 907 | 814 | 795 | 774 | 910 | 1119 | 997 | 966 | 962 | 927 | 9171 | TBC | TBC |
| Agency - Other (£000s) | 9796 | 711 | 762 | 1361 | 862 | 785 | 723 | 957 | 940 | 948 | 998 | 1048 | 811 | 954 | 9026 | TBC | TBC |
| **Sickness absence rate** | | | | | | | | | | | | | | | | | |
| Sickness Absence Rate % | 3.2% | 3.5% | 3.3% | 3.1% | 3.0% | 3.0% | 3.0% | 3.0% | 3.0% | 3.0% | 3.3% | 3.0% | 3.1% | 3.0% | 3.0% | <=2.9% | >3.2% |
| **Appraisal rates** | | | | | | | | | | | | | | | | | |
| Appraisal (non Medical) % | N/A | 53.5% | 51.5% | 51.5% | 42.0% | | | | | 27.0% | 30.0% | 31.0% | 30.0% | 32.0% | | >=80.0% | <70.0% |
| Appraisal (Medical) % | N/A | | | | 92.2% | 93.8% | 94.2% | 94.2% | 96.6% | 95.7% | 92.1% | 92.3% | 91.2% | 92.4% | | >=80.0% | <70.0% |
| **Training rate ***** | | | | | | | | | | | | | | | | | |
| Statutory & Mandatory Training % | N/A | | | | 45.7% | 50.9% | 44.5% | 48.9% | 51.7% | **** | **** | **** | **** | **** | N/A | >=85.0% | <60.0% |
| **Friends & family test for staff - % recommending here as a place to work** | | | | | | | | | | | | | | | | | |
| Staff FFT | N/A | 64.2% | | | 63.9% | | | 65.6% | | | | | | | N/A | N/A | N/A |

*Targets amended in Aug 2015 and applied retrospectively to Turnover and Vacancy rates; target added for Agency spend in Aug 2015 and applied retrospectively*
** "YTD" figures for turnover and sickness absence are the average performance over the past 12 months*
*** Budgets for 2015/16 have been aligned with ESR in July 2015 providing a more comprehensive position for vacancies at FPH. This has been applied retrospectively from April 2015*
**** The appraisal trackers were taken off-line in June 2015 to develop them from the legacy organisations to reflect the new structure of Frimley Health. The development work was completed and the trackers made live again in September 2015*
***** ESR is being standardised trust-wide and reporting will form part of this work – interim reporting in the form of a single % compliance figure will not be available until this work is completed and WIRED is reinstated. A work programme is currently being drawn up – dates to follow*

# Efficiency & Finance – Efficiency Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Outpatients** | ▪ Outpatient new to follow-up ratios have improved slightly<br>▪ DNA rates have stayed the same at 6.5% | |
| **Average length of stay** | ▪ There has been an improvement in both elective and non-elective average length of stay (LOS) during January 2016 | |
| **Daycase rate** | ▪ Day case rates have improved to 82% | |

# Efficiency & Finance – Efficiency Key measures

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatients **** | | | | | | | | | | | | | | | | | |
| Did not attend (DNA) rates | 6.8% | 6.8% | 6.2% | 6.3% | 6.5% | 6.6% | 6.4% | 6.5% | 6.7% | 6.7% | 6.1% | 6.2% | 6.5% | 6.5% | 6.5% | <=7.7% | >10.2% |
| Outpatient follow-up ratios | 2.14 | 2.21 | 2.16 | 2.23 | 2.24 | 2.23 | 2.16 | 2.14 | 2.15 | 2.18 | 2.17 | 2.08 | 2.20 | 2.19 | 2.17 | <=2.13 | >3.30 |
| **Average length of stay *** | | | | | | | | | | | | | | | | | |
| Elective length of stay | 2.55 | 2.42 | 2.53 | 2.55 | 2.58 | 2.58 | 2.39 | 2.23 | 2.42 | 2.71 | 2.81 | 2.54 | 2.57 | 2.24 | 2.51 | <=2.72 | >3.41 |
| Non-elective length of stay | 4.18 | 4.47 | 4.39 | 4.04 | 4.22 | 4.12 | 4.33 | 4.12 | 3.95 | 4.16 | 4.00 | 4.23 | 3.99 | 3.97 | 4.11 | <=3.97 | >5.16 |
| **Day case rate **** | | | | | | | | | | | | | | | | | |
| % day cases of all electives | 81% | 83% | 80% | 80% | 80% | 80% | 80% | 81% | 81% | 82% | 80% | 80% | 81% | 82% | 80% | >=78% | <68% |

** The targets and thresholds for the average length of stay measures have been adjusted to reflect the activity and specialty mix trust-wide and for each site from September 2015 and applied retrospectively*

*** The targets and thresholds for the outpatient measures and the day case rate have been adjusted to reflect the activity and specialty mix trust-wide and for each site from November 2015 and applied retrospectively*

# Efficiency & Finance – Finance Key messages

| Area | Key points | Action taken |
|---|---|---|
| **Income** | ▪ Year to date operating income is £10.5m ahead of plan. The forecast variance on operating income is £12.2m (subject to confirmation with CCGs)<br>▪ Additional non-recurrent support of £13m means that the trust will declare a surplus of £1m at the year-end | ▪ CCGs settled on prior year outturn and have acknowledged over-performance |
| **Expenditure** | ▪ Operating expenditure is £10.7m over original plan YTD. Agency costs continue to be flat and non-pay has returned to expected levels after last month's unusual performance (catch up)<br>▪ Integration and transaction spend is £10.7m YTD which is matched to income on a spend-recover basis | ▪ Focus needs to continue on recruitment and ensuring rotas are delivered to plan |
| **Net surplus/ deficit** | ▪ Broadly on plan in-month but because of £13m agreed additional non-recurrent support, the year-end forecast is now £1m surplus | ▪ None not covered elsewhere |
| **CIPs** | ▪ The trust's annual plan assumes delivery of a minimum of £21.4m of savings schemes. In month 10 the trust has delivered £2.0m of schemes against a plan of £1.9m<br>▪ Year to date the position is £1.25m adverse (£19.6m against a target of £20.9m) | ▪ None required at this stage |
| **Cash balance** | ▪ In-month the trust is £7.2m above a plan of £46.5m due largely to improvement in working capital, ie increase in payables.<br>▪ The forecast capital under-spend plus the additional Department of Health support of £10m, due to be invoiced before the year-end, means the forecast year-end balance is now £13.7m above the plan at £60.6m | ▪ Consideration on operation impact of capital slippage needed. Monies are available to carry forward |
| **Capital expenditure** | ▪ The trust is £2.9m under in-month increasing the YTD under-spend to £20.1m and hence a revision in the full year forecast to £23.5m against an original forecast of £41.2m. Slippage on the modular ward, car park and estates program (all at HWP) comprise the main causes of the underspend | ▪ None as capital can be carried forward as long as essential infrastructure and equipment is maintained |

# Efficiency & Finance - Finance Key measures

| | Year to Date (Month 10) | | | | | Forecast Outturn | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Target | Threshold | Plan £m | Actual £m | Variance £m | Target | Threshold |
| **Income** | 490.7 | 505.6 | 14.9 | 0.0 | (0.4) | 590.1 | 619.8 | 29.7 | 0.0 | (0.4) |
| **Expenditure** | 476.1 | 492.1 | (16.0) | 0.0 | (0.4) | 575.4 | 590.4 | (15.0) | 0.0 | (0.4) |
| **EBITDA** | 14.6 | 13.5 | (1.1) | 0.0 | (0.4) | 14.7 | 29.4 | 14.7 | 0.0 | (0.4) |
| **Financing costs** | 23.9 | 23.8 | 0.1 | 0.0 | (0.4) | 28.9 | 28.4 | 0.5 | 0.0 | (0.4) |
| **Net / surplus deficit** | (9.3) | (10.3) | (1.0) | 0.0 | (0.4) | (14.2) | 1.0 | 15.2 | 0.0 | (0.4) |
| **CIPs*** | 18.8 | 17.7 | (1.1) | 0.0 | (1.0) | 21.4 | 19.8 | (1.6) | 0.0 | (0.4) |
| **CIPs stretch target** | 2.1 | 2.0 | (0.1) | 0.0 | (0.4) | 3.1 | 2.4 | (0.7) | 0.0 | (0.4) |
| **Cash balance** | 46.5 | 53.7 | 7.2 | 0.0 | (0.4) | 46.9 | 60.6 | 13.7 | 0.0 | (0.4) |
| **Capital expenditure** | 34.3 | 14.2 | (20.1) | 0.0 | (0.4) | 41.2 | 23.5 | (17.7) | 0.0 | (0.4) |

*Figures in brackets indicate an adverse position*
** Dec 2015 – threshold amended for CIPs and applied retrospectively*

# CQUIN – Key messages

| Area | Key points | Action taken |
|---|---|---|
| **National CQUIN Acute Kidney Injury (AKI)** | ▪ The acute kidney injury (AKI) CQUIN performance is improving across both sites. However the national target of 90% set for Quarter 4 remains a significant challenge | ▪ Key messages on AKI recognition and interventions continue, with formal and informal training programmes in place on all sites<br>▪ Chiefs of service and consultants have been requested to provide support and clinical leadership to encourage an improvement in completion of AKI information on discharge summaries |
| **National CQUIN Sepsis** | ▪ Targets for screening for sepsis for the CQUIN have been achieved for Quarter 3, with a 100% on the FPH site and a significant improvement showing on the HWP site<br>▪ Administration of antibiotics within the hour remains challenging | ▪ Funding has been agreed for a three-month Band 6 secondment in ED at FPH to support sepsis care<br>▪ AKI and sepsis nurse specialists are in post on HWP site supporting the clinical improvements<br>▪ AKI and sepsis groups are now in place on both sites |
| **National CQUIN Dementia** | ▪ All Dementia Care CQUIN requirements have been met for Quarter 3 across Frimley Health | |
| **National CQUIN Ambulatory Care** | ▪ All Ambulatory Care CQUIN milestones have been achieved for Frimley Health for Quarter 3 | |
| **Local CQUIN Trusted Assessors** | ▪ This CQUIN has been closed down with CCG agreement for the HWP site<br>▪ All Trusted Assessor CQUIN milestones have been achieved for Quarter 3 on the FPH site | |
| **Local CQUIN Promoting Safe Transfer of Care** | ▪ All Safe Transfer of Care milestones have been achieved for Frimley Health for Quarter 3 | |
| **Local CQUIN Patients and Carers as partners in care** | ▪ All Carers CQUIN milestones have been achieved for Frimley Health for Quarter 3 | |
| **Local CQUIN Older People Living with frailty** | ▪ All Frailty CQUIN milestones have been achieved for Frimley Health for Quarter 3 | |

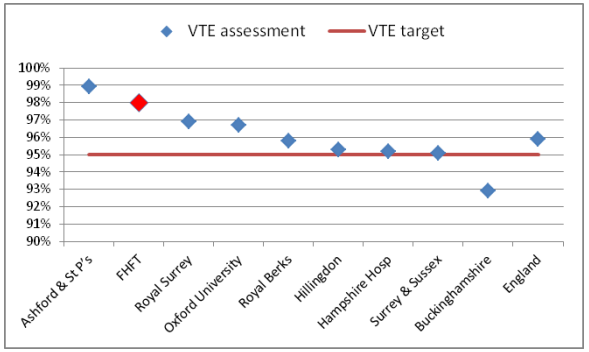
# CQUIN - National CQUIN performance

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Acute kidney injury CQUIN** | | | | | | | | | | | | | | | | | |
| The percentage of key items included in the reviewed AKI discharge summaries | New | | | | 27% | 26% | 26% | 25% | 40% | 39% | 57% | 60% | 65% | Data submitted quarterly | | TBC* | |
| **Sepsis CQUIN** | | | | | | | | | | | | | | | | | |
| The percentage of patients who met the criteria of the local protocol for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate (Part 1) | New | | | | 22% | 22% | 25% | 60% | 73% | 73% | 90% | 92% | 87% | Data submitted quarterly | | TBC* | |
| The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies, and were administered intravenous antibiotics within 1 hour of arrival (Part 2) | New | | | | Not required in Q1 | | | 60% | 73% | 73% | 71% | 75% | 78% | Data submitted quarterly | | TBC* | |
| **Dementia Care CQUIN** | | | | | | | | | | | | | | | | | |
| % of all admitted patients (75+) who have been screened for Dementia (within 72 hours) | 95% | 95% | 96% | 95% | 97% | 97% | 97% | 96% | 97% | 94% | 93% | 93% | 93% | 96% | 95% | 90% | |
| % of all admitted patients (75+) who scored positively on the dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) | 97% | 96% | 98% | 96% | 99% | 97% | 95% | 97% | 98% | 95% | 97% | 100% | 99% | 96% | 97% | 90% | |
| % of all admitted patients (75+) who received a dementia diagnostic assessment with a “positive” or “inconclusive" outcome that were then referred for further diagnostic advice/follow up (within 72 hours) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% | |
| Delivery of dementia training programme (Level one only) - staff trained to date | New | | | | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | in arrears | TBC* | |

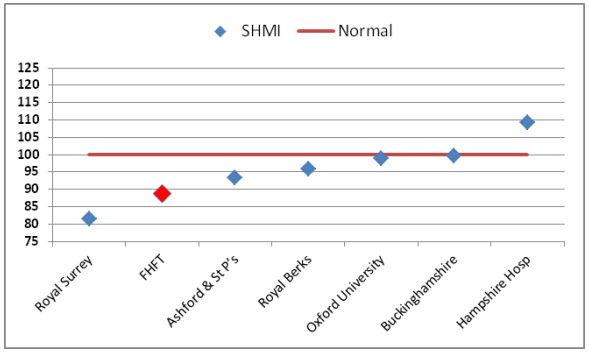
* *Local targets to be agreed with commissioners shortly*

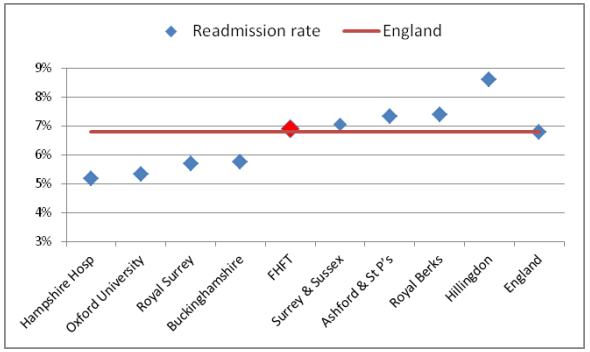
# Benchmarking – selected measures

## Safe

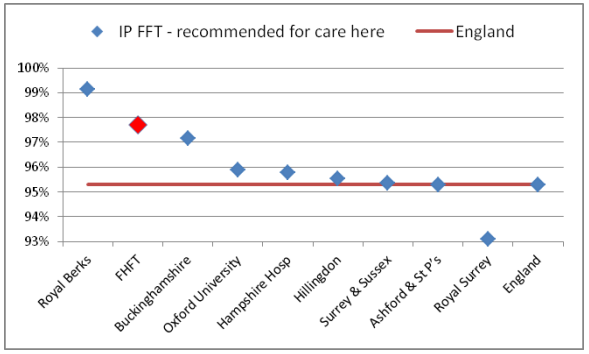


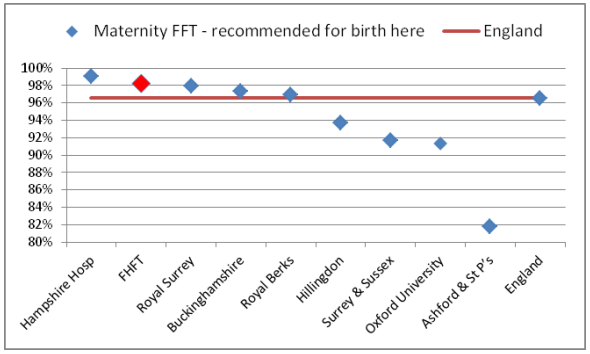

## Effective

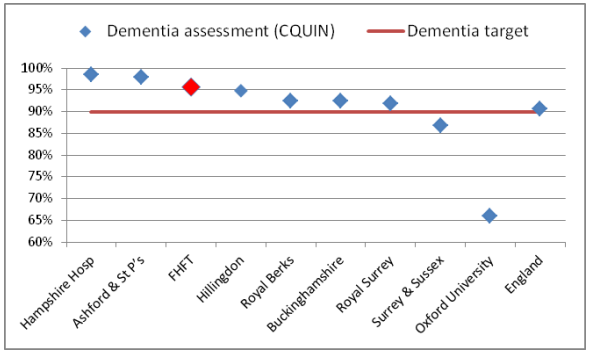



## Caring



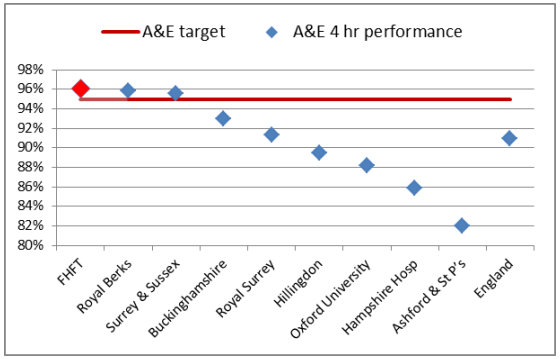



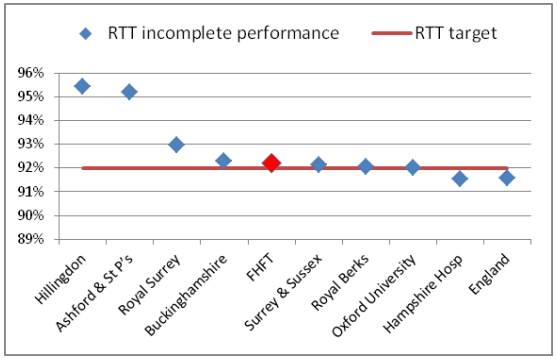



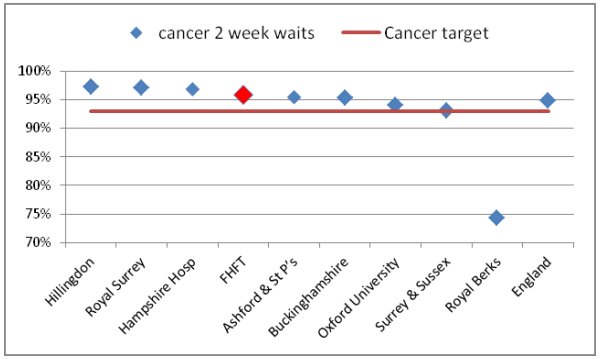

***Data periods:*** *VTE = Q2 2015/16; SHMI = Oct 2014 – Sep 2015; Readmissions = Oct 2015; IP FFT (friends & family test) = Dec2015; Maternity FFT = Dec2015; Dementia = Q2 2015/16*

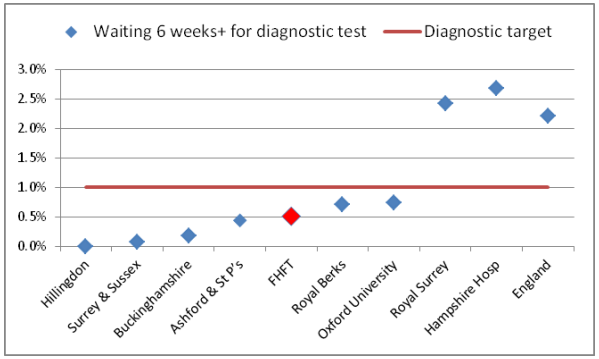
# Benchmarking – selected measures

## Responsive

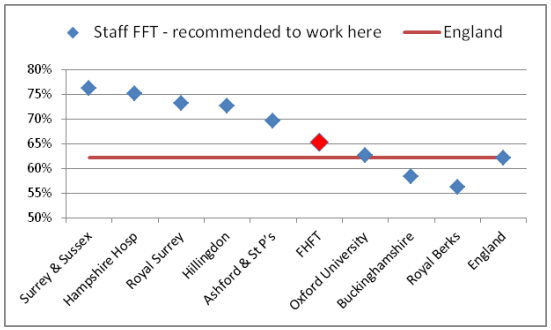


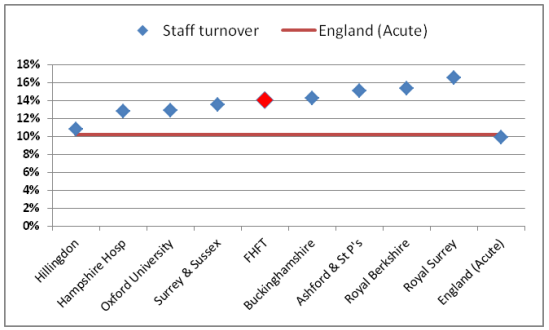




## Workforce




***Data periods:*** *A&E (4 hour target) = Dec 2015; RTT (incomplete pathways) = Dec 2015; Diagnostic test waits = Dec2015; Cancer = Q3 2015/16; Staff FFT (friends & family test) = Q2 2015/16; Staff turnover = Sep 2015*

# Activity

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | YTD % change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GP and general dental practitioner referrals to all outpatients** | | | | | | | | | | | | | | | | |
| NHS North East Hampshire & Farnham | 38896 | 3073 | 3165 | 3673 | 3153 | 3105 | 3204 | 3439 | 2793 | 3738 | 3974 | 3566 | 3146 | 3456 | 33574 | 5% |
| NHS Slough | 34220 | 2914 | 2826 | 3199 | 3008 | 3008 | 3217 | 3079 | 2837 | 3306 | 3048 | 2931 | 2995 | 3147 | 30576 | 8% |
| NHS Windsor, Ascot & Maidenhead | 30273 | 2583 | 2529 | 2796 | 2535 | 2662 | 2668 | 2590 | 2254 | 2661 | 2464 | 2588 | 2367 | 2511 | 25300 | 1% |
| NHS Bracknell & Ascot | 19346 | 1581 | 1472 | 1841 | 1566 | 1549 | 1556 | 1542 | 1460 | 1596 | 1727 | 1640 | 1379 | 1657 | 15672 | -2% |
| NHS Surrey Heath | 17262 | 1386 | 1363 | 1475 | 1428 | 1349 | 1518 | 1524 | 1223 | 1463 | 1485 | 1412 | 1275 | 1327 | 14004 | -3% |
| NHS Chiltern | 11989 | 1080 | 972 | 1232 | 1079 | 1096 | 1202 | 1108 | 1040 | 1180 | 1128 | 1133 | 1076 | 1155 | 11197 | 14% |
| Other CCG's | 15970 | 1315 | 1251 | 1411 | 1273 | 1187 | 1304 | 1337 | 1088 | 1369 | 1487 | 1401 | 1175 | 1296 | 12917 | -3% |
| Total | 167956 | 13932 | 13578 | 15627 | 14042 | 13956 | 14669 | 14619 | 12695 | 15313 | 15313 | 14671 | 13413 | 14549 | 143240 | 3% |
| % change on previous year | | -4% | 3% | 12% | 7% | 1% | 4% | 1% | 3% | 6% | -1% | 4% | 4% | 4% | | |
| **Outpatient attendances** | | | | | | | | | | | | | | | | |
| New attendances | 278481 | 23011 | 22323 | 23935 | 22393 | 21376 | 25147 | 24587 | 20738 | 24183 | 24091 | 24700 | 22033 | 22700 | 231948 | 0% |
| Follow-up attendances | 596390 | 50924 | 48139 | 53276 | 50158 | 47647 | 54309 | 52494 | 44505 | 52726 | 52249 | 52365 | 48504 | 49698 | 504655 | 2% |
| Total OP attendances | 874871 | 73935 | 70462 | 77211 | 72551 | 69023 | 79456 | 77081 | 65243 | 76909 | 76340 | 77065 | 70537 | 72398 | 736603 | 1% |
| % change on previous year | | -2% | 7% | 14% | 4% | -3% | 7% | 0% | 2% | 0% | -3% | 7% | 2% | -2% | | |
| **A&E attendances** | | | | | | | | | | | | | | | | |
| A&E attendances (total) | 220350 | 17104 | 16308 | 19430 | 18506 | 19560 | 19332 | 19450 | 18530 | 18800 | 19125 | 19144 | 19009 | 19580 | 191036 | 3% |
| % change on previous year | | -3% | -3% | -3% | 7% | 2% | 0% | 0% | 4% | 1% | 2% | 5% | 1% | 14% | | |
| **Non-elective admissions** | | | | | | | | | | | | | | | | |
| Non-elective admissions (total) | 85353 | 7741 | 7021 | 8125 | 7475 | 7694 | 7540 | 7878 | 7569 | 7876 | 8045 | 7993 | 8476 | 8345 | 78891 | 3% |
| % change on previous year | | 8% | 8% | 11% | 4% | 3% | 3% | 1% | 2% | 1% | -2% | 4% | 4% | 8% | | |
| **Elective admissions** | | | | | | | | | | | | | | | | |
| Daycase | 64560 | 5594 | 5332 | 6110 | 4955 | 4942 | 5585 | 5808 | 4853 | 5777 | 5670 | 5317 | 5100 | 5460 | 53467 | 1% |
| Overnight | 15127 | 1184 | 1303 | 1523 | 1267 | 1259 | 1434 | 1356 | 1156 | 1301 | 1438 | 1320 | 1207 | 1239 | 12977 | 5% |
| Regular day attenders | 15438 | 1340 | 1281 | 1476 | 1285 | 1264 | 1427 | 1485 | 1267 | 1435 | 1319 | 1234 | 1205 | 1304 | 13225 | 4% |
| Total elective admissions | 95125 | 8118 | 7916 | 9109 | 7507 | 7465 | 8446 | 8649 | 7276 | 8513 | 8427 | 7871 | 7512 | 8003 | 79669 | 2% |
| % change on previous year | | 2% | 9% | 16% | 0% | -6% | 10% | 5% | 7% | 8% | -1% | 0% | -1% | -1% | | |

# Appendices

# Appendices

# Appendix – Methodology for calculating the performance score

| | |
|---|---|
| **Step 1** | ▪ Measures that are RAG rated as **red** score 0 points; **amber** as 2 points and **green** as 4 points |
| **Step 2** | ▪ Identify which measures are "key" targets for the organisation; they may be CQC or Monitor targets or measures on which the trust is particularly focussing<br>▪ Key targets have scores multiplied by a factor of 3<br>▪ The proposed key targets are detailed on the next slide |
| **Step 3** | ▪ Apply the weighting for the key targets; add up the scores for the measures for that month per domain; divide by the maximum total score possible for that domain; multiply by 100 to get a percentage score |
| **Step 4** | ▪ Apply the thresholds for the overall domain to get a RAG rating for each domain<br>▪ These have been set as a score less than 50% is **red**, 75% or above is **green** and in between is **amber** |
| **Step 5** | ▪ Add up the score for the Monitor table using Monitor's weightings for each month and add to the score for the other "Responsive" section (RTT and diagnostic waits). Convert the overall score into a percentage out of the maximum possible score for the "Responsive" domain and RAG rate as in step 4 above<br>▪ Where data is "in arrears" eg cancer standards, use the score for the previous month for that measure as a proxy<br>▪ The manner in which performance against the "Monitor" measures is included in the overall score was changed from July 2015 and has been applied retrospectively |
| **Step 6** | ▪ Calculate the overall performance score by averaging the domain scores<br>▪ Apply the same thresholds of 50% and 75% to RAG rate the overall score |
| **Assumption** | ▪ Domains are of equal importance; the domain score is a proportional score out of the maximum possible score for that domain |

# Appendix – "Key" targets

The proposed "key" targets are all measures included in CQCs "Intelligent Monitoring" reports for acute trusts or form part of the quarterly monitoring by Monitor. In the new performance score methodology they are weighted more heavily.

| Domain | Measure |
|---|---|
| **Safe** | ▪ MRSA<br>▪ VTE assessments<br>▪ Never events |
| **Effective** | ▪ Overall SHMI<br>▪ Emergency readmissions<br>▪ Stroke - % of patients admitted directly to the stroke unit within 4 hours |
| **Caring** | ▪ Complaints proportional to activity undertaken<br>▪ Friends and family test |
| **Responsive & Monitor** | ▪ Diagnostics waiting over 6 weeks<br>▪ Clostridium difficile due to lapses of care<br>▪ A&E 4 hour target<br>▪ RTT target for incomplete pathways<br>▪ Cancer standards |
| **Workforce** | ▪ Turnover %<br>▪ Sickness % |
| **Efficiency & Finance** | ▪ Net / surplus deficit |

# Appendix - Safe - Key measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | |
| Clostridium difficile * | 10 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 2 | 2 | 5 | 4 | 0 | 0 | 15 | None | None |
| Clostridium difficile due to lapses in care | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 3 | 0 | 0 | 8 | <=11 | None |
| MRSA Bacteraemia | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | None |
| **Medication errors resulting in harm** | | | | | | | | | | | | | | | | | |
| Low | 12 | 1 | 1 | 1 | 4 | 5 | 2 | 0 | 1 | 3 | 2 | 2 | 2 | 3 | 24 | None | |
| Moderate * | 5 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | <=5 | None |
| Severe * | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | None |
| **Pressure Ulcer Incidence** | | | | | | | | | | | | | | | | | |
| Hospital acquired - grade 2 * | 94 | 10 | 6 | 5 | 15 | 7 | 5 | 7 | 2 | 5 | 4 | 7 | 4 | in arrears | 56 | <=86 | None |
| Hospital acquired - grade 3 * | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | in arrears | 4 | 4 | None |
| Hospital acquired - grade 4 * | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | in arrears | 0 | 0 | None |
| **Harm-free care (safety thermometer)** | 95.6% | 96.9% | 96.2% | 96.2% | 94.5% | 93.6% | 93.5% | 96.3% | 94.1% | 93.6% | 94.5% | 96.1% | 92.2% | 95.1% | 94.4% | >=95% | <89% |
| **VTE risk assessment** | 97.9% | 98.6% | 98.5% | 98.9% | 98.9% | 99.3% | 99.2% | 99.1% | 99.0% | 99.3% | 99.5% | 99.3% | 99.3% | 99.2% | 99.2% | >=95% | None |
| **Never Events** | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | None |
| **Serious Incidents Requiring Investigation (SIRI) *** | 48 | 3 | 3 | 6 | 2 | 1 | 4 | 4 | 3 | 0 | 4 | 1 | 5 | 2 | 26 | <=45 | >4 |
| **Falls resulting in significant injury** | | | | | | | | | | | | | | | | | |
| Number of falls * | 22 | 1 | 1 | 2 | 1 | 0 | 2 | 1 | 0 | 0 | 2 | 1 | 2 | 3 | 12 | <=20 | None |
| Number of falls per 1000 bed days | 0.10 | 0.05 | 0.05 | 0.10 | 0.05 | 0.00 | 0.10 | 0.05 | 0.00 | 0.00 | 0.10 | 0.05 | 0.10 | 0.14 | 0.06 | TBC | |
| **Nurse Staffing - appropriate staffing levels** | | | | | | | | | | | | | | | | | |
| Medicine - overall staff | 99% | 99% | 100% | 101% | 102% | 102% | 99% | 99% | 99% | 99% | 98% | 99% | 99% | 99% | 100% | >=90% | None |
| Surgery - overall staff | 99% | 99% | 98% | 99% | 101% | 105% | 101% | 100% | 102% | 101% | 101% | 101% | 100% | 101% | 101% | >=90% | None |
| Medicine - registered staff | 98% | 98% | 99% | 101% | 100% | 99% | 93% | 92% | 91% | 91% | 92% | 95% | 96% | 96% | 94% | >=90% | None |
| Surgery - registered staff | 96% | 97% | 96% | 98% | 97% | 100% | 95% | 94% | 96% | 96% | 94% | 97% | 96% | 97% | 96% | >=90% | None |
| **National Safe Staffing Programme - as reported by NHS Choices (Compliance: planned number nursing hours versus actual)** | | | | | | | | | | | | | | | | | |
| Overall Compliance | 100% | 101% | 98% | 101% | 99% | 101% | 99% | 97% | 96% | 99% | 99% | 99% | 95% | 97% | 98% | >=90% | None |

** Monthly targets are as follows: C. difficile (1);moderate medication errors (0); severe medication errors (0); Pressure ulcers grade 2 (6); grade 3 (0); grade 4 (0); SIRI (3); Falls (1)*

# Appendix - Safe - Key measures (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | |
| Clostridium difficile * | 23 | 3 | 2 | 1 | 3 | 1 | 2 | 5 | 3 | 4 | 1 | 0 | 2 | 1 | 22 | None | None |
| Clostridium difficile due to lapses in care | 4 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | <=20 | None |
| MRSA Bacteraemia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 0 | None |
| **Medication errors resulting in harm** | | | | | | | | | | | | | | | | | |
| Low | 432 | 29 | 30 | 21 | 12 | 4 | 0 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 26 | None | |
| Moderate * | 42 | 2 | 0 | 5 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | <=38 | None |
| Severe * | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | None |
| **Pressure Ulcer Incidence** | | | | | | | | | | | | | | | | | |
| Hospital acquired - grade 2 * | 146 | 15 | 13 | 7 | 8 | 12 | 4 | 3 | 5 | 3 | 5 | 4 | 5 | in arrears | 49 | <=130 | None |
| Hospital acquired - grade 3 * | 16 | 2 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | in arrears | 2 | 8 | None |
| Hospital acquired - grade 4 * | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | in arrears | 0 | 0 | None |
| **Harm-free care (safety thermometer)** | 94.8% | 95.3% | 95.2% | 95.5% | 95.2% | 94.1% | 95.7% | 95.1% | 95.3% | 95.5% | 96.7% | 96.3% | 96.0% | 94.7% | 95.5% | >=95% | <89% |
| **VTE risk assessment** | 96.2% | 97.3% | 97.5% | 97.9% | 96.7% | 98.1% | 97.8% | 98.0% | 100.0% | 96.1% | 95.7% | 96.4% | 95.4% | | 97.1% | >=95% | None |
| **Never Events** | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 3 | 0 | None |
| **Serious Incidents Requiring Investigation (SIRI) *** | 49 | 8 | 5 | 4 | 3 | 2 | 4 | 6 | 3 | 3 | 2 | 5 | 5 | 4 | 37 | <=45 | >4 |
| **Falls resulting in significant injury** | | | | | | | | | | | | | | | | | |
| Number of falls * | 19 | 4 | 1 | 1 | 1 | 2 | 1 | 1 | 0 | 1 | 1 | 3 | 1 | 2 | 13 | <=17 | None |
| Number of falls per 1000 bed days | 0.09 | 0.22 | 0.06 | 0.06 | 0.06 | 0.12 | 0.06 | 0.06 | 0.00 | 0.06 | 0.06 | 0.18 | 0.06 | 0.11 | 0.08 | TBC | |
| **Nurse Staffing - appropriate staffing levels** | | | | | | | | | | | | | | | | | |
| Medicine - overall staff | 98% | 99% | 101% | 100% | 102% | 91% | 99% | 103% | 97% | 100% | 100% | 98% | 94% | 96% | 98% | >=90% | None |
| Surgery - overall staff | 94% | 93% | 92% | 92% | 97% | 94% | 103% | 96% | 96% | 94% | 98% | 90% | 94% | 98% | 96% | >=90% | None |
| Medicine - registered staff | 99% | 99% | 101% | 100% | 102% | 91% | 99% | 103% | 97% | 100% | 100% | 98% | 94% | 96% | 98% | >=90% | None |
| Surgery - registered staff | 94% | 93% | 92% | 92% | 97% | 94% | 103% | 96% | 96% | 94% | 98% | 90% | 94% | 98% | 96% | >=90% | None |
| **National Safe Staffing Programme - as reported by NHS Choices (Compliance: planned number nursing hours versus actual)** | | | | | | | | | | | | | | | | | |
| Overall Compliance | 97% | 97% | 98% | 97% | 99% | 92% | 100% | 100% | 96% | 97% | 97% | 94% | 93% | 95% | 96% | >=90% | None |

** Monthly targets are as follows: C. difficile (2);moderate medication errors (3); severe medication errors (0); Pressure ulcers grade 2 (10); grade 3 (0); grade 4 (0); SIRI (3); Falls (1)*

# Appendix - Effective - Mortality trends

| FPH | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality (one month's data)** | | | | | | | | | | | | | | | | | |
| Number of deaths | 1239 | 131 | 119 | 107 | 99 | 97 | 83 | 99 | 82 | 118 | 104 | 106 | 115 | 116 | 1019 | TBC | |
| Number of discharges | 108234 | 8642 | 8870 | 10129 | 8669 | 8693 | 9375 | 9776 | 8394 | 9690 | 9606 | 9131 | 9273 | 9580 | 92187 | TBC | |
| % deaths | 1.1% | 1.5% | 1.3% | 1.1% | 1.1% | 1.1% | 0.9% | 1.0% | 1.0% | 1.2% | 1.1% | 1.2% | 1.2% | 1.2% | 1.1% | TBC | |
| **SHMI (Summary hospital-level mortality indicator) (12 months' rolling data)** | | | | | | | | | | | | | | | | | |
| Overall observed number of deaths | | 1674 | 1702 | 1700 | 1719 | 1728 | 1733 | 1736 | 1732 | 1776 | 1771 | in arrears | in arrears | in arrears | | TBC | |
| Overall expected number of deaths | | 1870 | 1886 | 1897 | 1919 | 1930 | 1940 | 1956 | 1974 | 1987 | 1994 | in arrears | in arrears | in arrears | | TBC | |
| Overall SHMI rate | | 90 | 90 | 90 | 90 | 90 | 89 | 89 | 88 | 89 | 89 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Non-elective SHMI rate | | 90 | 90 | 89 | 89 | 89 | 89 | 89 | 88 | 90 | 89 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Elective SHMI rate | | 104 | 109 | 101 | 101 | 95 | 92 | 81 | 74 | 73 | 73 | in arrears | in arrears | in arrears | | <=100 | >125 |

| HWP | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality (one month's data)** | | | | | | | | | | | | | | | | | |
| Number of deaths | 1231 | 141 | 103 | 123 | 102 | 107 | 96 | 86 | 89 | 91 | 85 | 107 | 119 | 87 | 969 | TBC | |
| Number of discharges | 90949 | 7285 | 7053 | 8178 | 7339 | 7571 | 7734 | 7956 | 7376 | 7750 | 8095 | 7842 | 7910 | 7845 | 77418 | TBC | |
| % deaths | 1.4% | 1.9% | 1.5% | 1.5% | 1.4% | 1.4% | 1.2% | 1.1% | 1.2% | 1.2% | 1.1% | 1.4% | 1.5% | 1.1% | 1.3% | TBC | |
| **SHMI (Summary hospital-level mortality indicator) (12 months' rolling data)** | | | | | | | | | | | | | | | | | |
| Overall observed number of deaths | | 1568 | 1590 | 1652 | 1677 | 1692 | 1694 | 1683 | 1701 | 1709 | 1686 | in arrears | in arrears | in arrears | | TBC | |
| Overall expected number of deaths | | 1619 | 1634 | 1704 | 1716 | 1732 | 1743 | 1748 | 1760 | 1771 | 1775 | in arrears | in arrears | in arrears | | TBC | |
| Overall SHMI rate | | 97 | 97 | 97 | 98 | 98 | 97 | 96 | 97 | 97 | 95 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Non- elective SHMI rate | | 97 | 97 | 97 | 98 | 98 | 97 | 96 | 97 | 96 | 95 | in arrears | in arrears | in arrears | | <=100 | >125 |
| Elective SHMI rate | | 115 | 110 | 104 | 99 | 92 | 87 | 101 | 102 | 102 | 98 | in arrears | in arrears | in arrears | | <=100 | >125 |

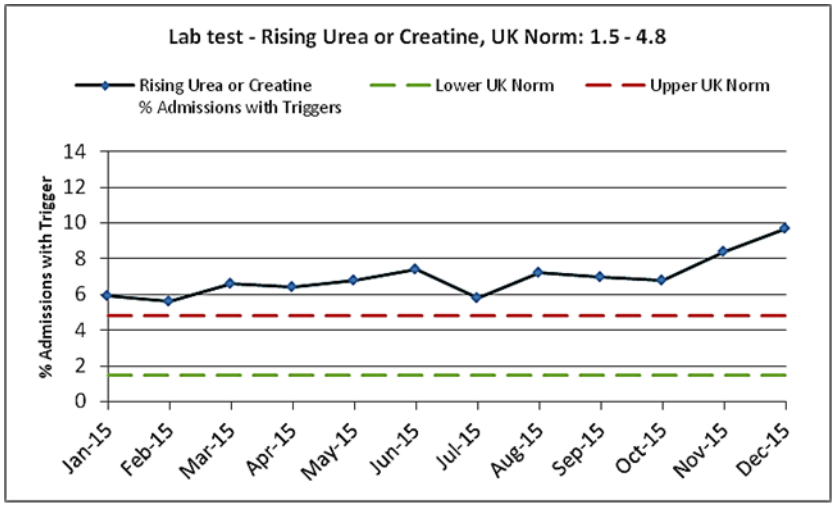
***KEY:*** *Higher than expected* | *Within expected range* | *Lower than expected*

# Appendix - Effective - CRAB medical practice trigger trends (FPH)

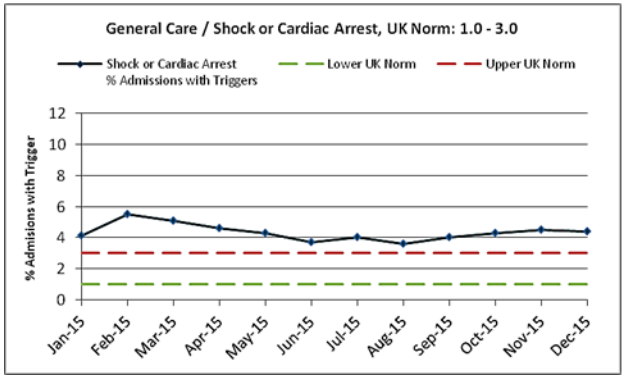
**Key messages**

- Nosocomial (hospital acquired) pneumonia (HAP) and rising urea and creatinine (a surrogate measure of acute kidney injury (AKI)) are above the quoted national norm at FPH
- Missed early warning score rates have increased in the last two quarters, but are still close to the upper limit of normal
- AKI has increased and this is undergoing investigation
- There is a trend towards reduction in incidence of HAP since January 2015
- AKI care bundles have been launched this year

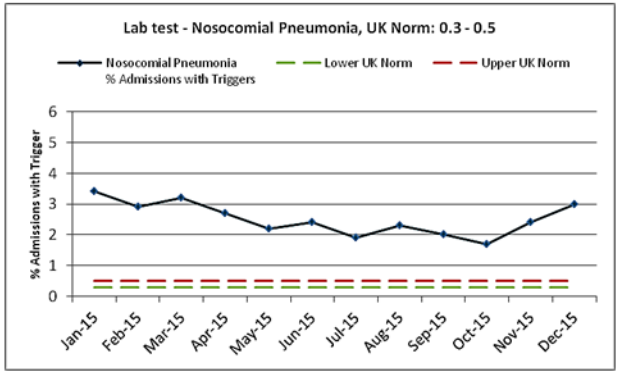
## Rising urea or creatinine



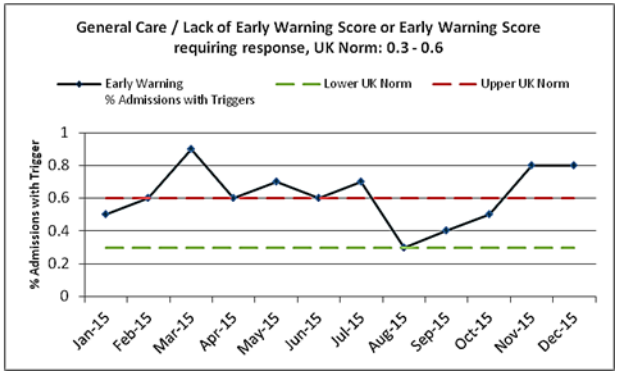

## Shock or cardiac arrest




## Nosocomial pneumonia




## Early warning

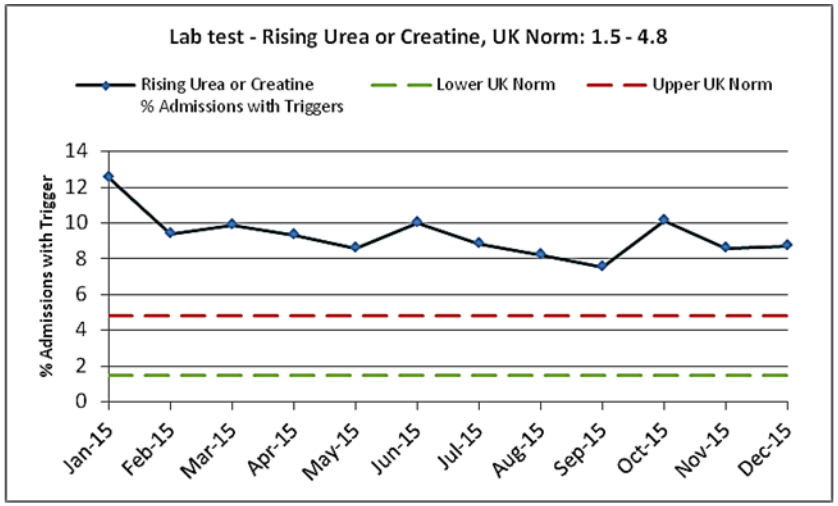


# Appendix - Effective - CRAB medical practice trigger trends (HWP)

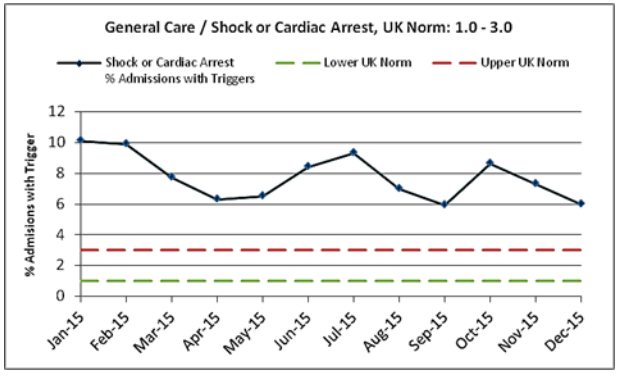
**Key messages**

- An acute kidney injury (AKI) audit at HWP has shown that only 15% of cases in June were hospital acquired; the rest were present on admission to hospital. Preventable causes of hospital acquired AKI are being sought through a case note review to help direct improvement measures
- The AKI CQUIN aims to optimise transition of care of AKI patients from hospital to the GP by accurate detailed discharge summary
- There is a trend towards reduction in the incidence of hospital acquired pneumonia (HAP), hypotension/cardiac arrest and missed early warning score since January 2015
- The “deteriorating patient” project and sepsis CQUIN continue on both sites

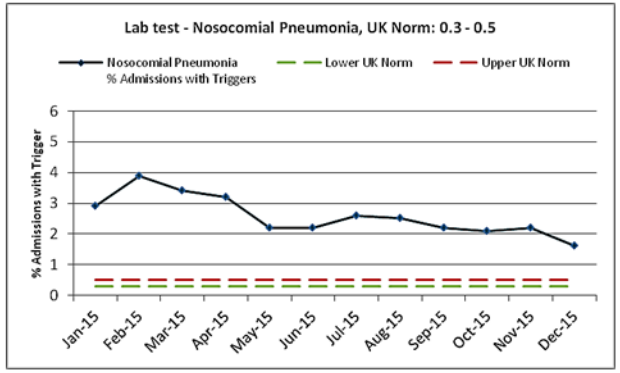
## Rising urea or creatinine



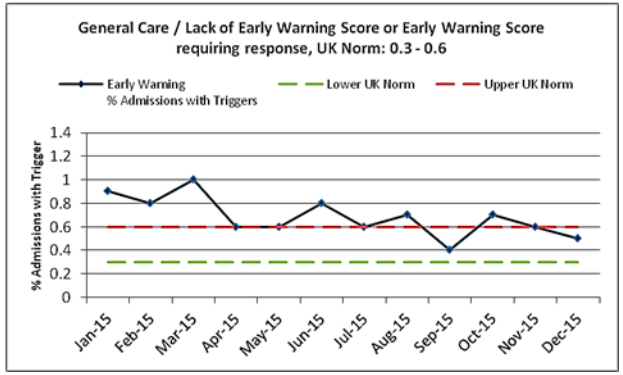

## Shock or cardiac arrest




## Nosocomial pneumonia




## Early warning



# Appendix - Effective - Clinical performance measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Stroke** | | | | | | | | | | | | | | | | | |
| % of patients admitted directly to the stroke unit in 4 hours | 75% | 77% | 75% | 79% | 78% | 70% | 70% | 78% | 73% | 74% | 65% | 57% | 51% | 55% | 67% | >=75% | <72% |
| **Cardiology** | | | | | | | | | | | | | | | | | |
| % of eligible patients receive treatment; call to balloon within 150 minutes | 91% | 89% | 100% | 94% | 90% | 94% | 88% | 100% | 94% | 100% | 100% | 94% | 100% | in arrears | 95% | >=85% | <80% |
| **Trauma and orthopaedics** | | | | | | | | | | | | | | | | | |
| % of patients who received surgery within 36 hours for a fractured neck of femur | 91% | 92% | 88% | 89% | 84% | 87% | 80% | 81% | 92% | 91% | 84% | 88% | 86% | 92% | 86% | >=90% | <80% |
| **Obstetrics** | | | | | | | | | | | | | | | | | |
| Caesarean section rate (planned & unscheduled) | 24% | 24.1% | 23.5% | 28.8% | 23.1% | 24.0% | 25.7% | 26.5% | 25.2% | 25.9% | 23.7% | 26.6% | 27.0% | 26.4% | 25.4% | <=23% | >26% |

# Appendix - Effective - Clinical performance measures (HWP)

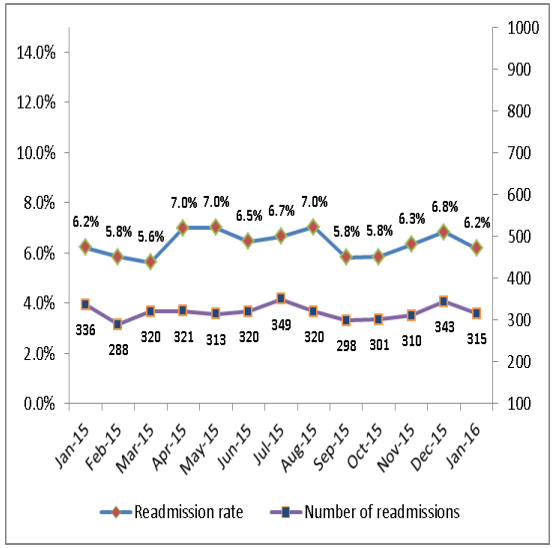
| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Stroke** | | | | | | | | | | | | | | | | | |
| % of patients admitted directly to the stroke unit in 4 hours | 67% | 55% | 29% | 78% | 58% | 74% | 60% | 73% | 61% | 59% | 58% | 79% | 58% | 70% | 65% | >=75% | <72% |
| **Cardiology** | | | | | | | | | | | | | | | | | |
| % of eligible patients receive treatment; call to balloon within 150 minutes | 86% | 100% | 100% | 100% | 75% | 75% | 100% | 100% | 100% | 100% | 100% | 60% | 75% | 100% | 86% | >=85% | <80% |
| **Trauma and orthopaedics** | | | | | | | | | | | | | | | | | |
| % of patients who received surgery within 36 hours for a fractured neck of femur | 80% | 86% | 86% | 74% | 92% | 86% | 85% | 94% | 89% | 73% | 84% | 94% | 85% | 80% | 86% | >=90% | <80% |
| **Obstetrics** | | | | | | | | | | | | | | | | | |
| Caesarean section rate (planned & unscheduled) | 29% | 37.2% | 30.3% | 29.4% | 30.3% | 27.0% | 27.0% | 25.6% | 22.8% | 24.9% | 28.5% | 27.0% | 27.6% | 23.6% | 26.4% | <=23% | >26% |

# Appendix - Effective – Emergency readmission trends (FPH)

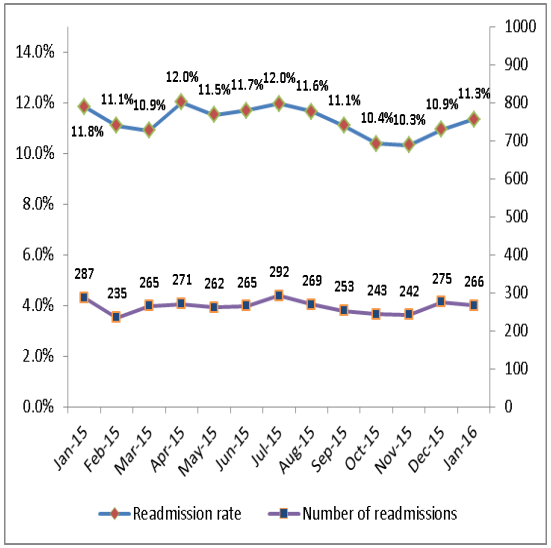
Lower readmission rates can be taken to indicate a higher quality service to patients as well as reducing costs for hospitals. The data is based on the number of patients who are readmitted to any specialty at either FPH or HWP within 30 days as an emergency following a previous elective or non-elective spell. The readmission spell must be an overnight stay.

FPH

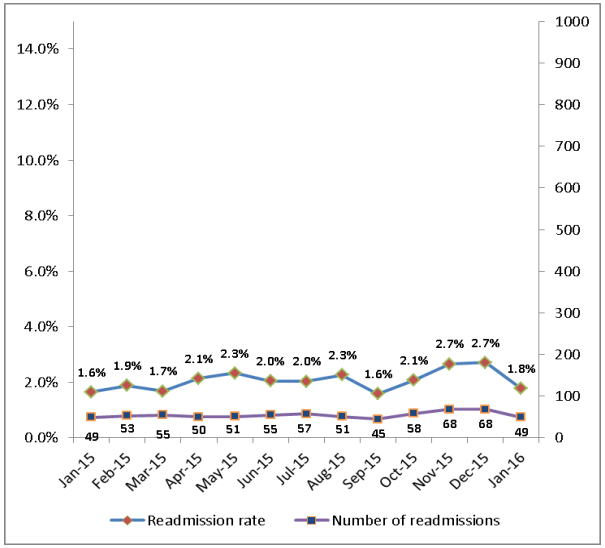
## Overall emergency readmissions




## Emergency readmissions following an emergency admission




## Emergency readmissions following an elective admission

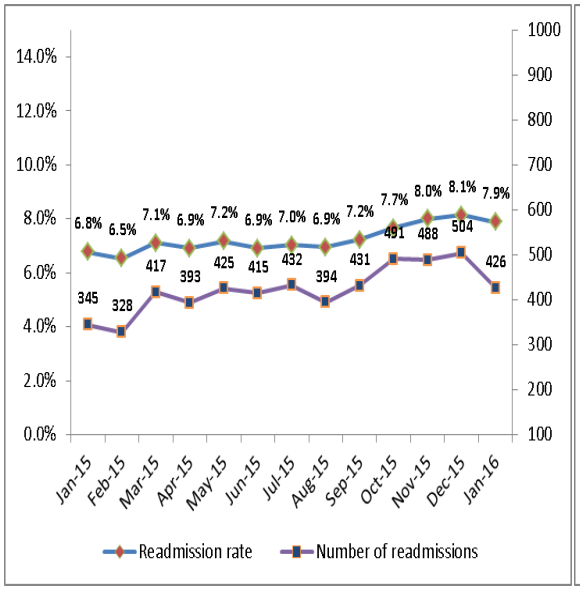


# Appendix - Effective – Emergency readmission trends (HWP)

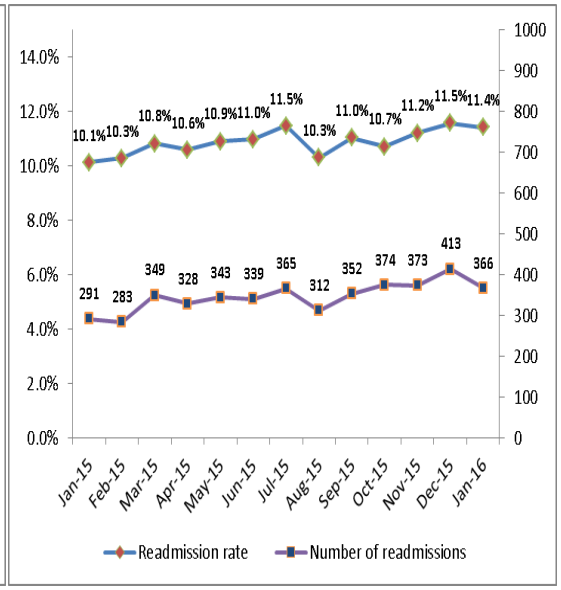
Lower readmission rates can be taken to indicate a higher quality service to patients as well as reducing costs for hospitals. The data is based on the number of patients who are readmitted to any specialty at either FPH or HWP within 30 days as an emergency following a previous elective or non-elective spell. The readmission spell must be an overnight stay.

HWP

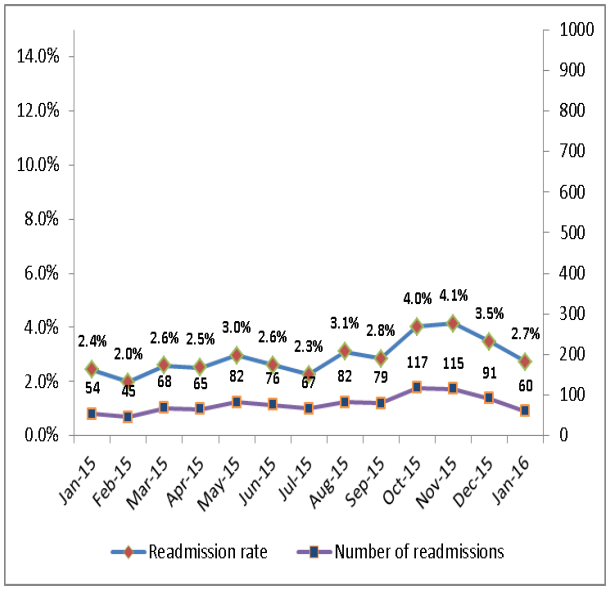
## Overall emergency readmissions




## Emergency readmissions following an emergency admission




## Emergency readmissions following an elective admission



# Appendix - Caring - Key measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Local Surveys (trust-wide measures are being reviewed; a new trust-wide survey will commence in 2015/16)** | | | | | | | | | | | | | | | | | |
| 1. Overall did you feel you were treated with respect and dignity whilst in hospital? | New | | | | 94% (129/137) | 98% | 96% | 94% | 95% | 97% | 96% | 97% | 98% | 97% (437/449) | 96% | >=90% | <80% |
| 2. Were you given enough privacy on the ward? | New | | | | 94% (129/137) | 96% | 95% | 97% | 95% | 95% | 96% | 96% | 97% | 96% (414/430) | 96% | >=90% | <80% |
| 3. Do you have confidence and trust in the doctors treating you? | New | | | | 88% (121/137) | 93% | 91% | 94% | 92% | 94% | 94% | 91% | 95% | 94% (421/447) | 93% | >=90% | <80% |
| 4. Were you bothered by noise at night from staff? (percentage of patients saying no) | New | | | | 85% (116/137) | 85% | 88% | 91% | 88% | 86% | 88% | 83% | 85% | 85% (380/447) | 87% | >=80% | <70% |
| 5. Were you bothered by noise at night from other patients? (percentage of patients saying no) | New | | | | 61% (84/137) | 68% | 74% | 73% | 72% | 67% | 69% | 65% | 68% | 64% (288/449) | 69% | >=75% | <65% |
| 6. Have you noticed a difference in the quality of your care at different times of the day or week? | New | | | | 91% (125/137) | 87% | 88% | 93% | 91% | 88% | 91% | 88% | 94% | 90% (392/434) | 90% | >=90% | <80% |
| 7. Do you get enough help from staff to eat your meals? | New | | | | 89% (49/55) | 93% | 82% | 92% | 91% | 86% | 87% | 87% | 97% | 92% (122/133) | 89% | >=90% | <80% |
| 8. Do you feel that you and your family/carers have been involved in planning for your discharge from hospital? | New | | | | 71% (83/117) | 78% | 67% | 76% | 77% | 75% | 75% | 77% | 69% | 96% (176/183) | 75% | >=75% | <65% |
| 9. Did staff examining and treating for you introduce themselves? | New | | | | 93% (127/137) | 91% | 89% | 93% | 90% | 92% | 93% | 90% | 94% | 92% (411/449) | 91% | >=90% | <80% |
| **Complaints** | | | | | | | | | | | | | | | | | |
| Number of complaints received * | 426 | 40 | 25 | 37 | 37 | 28 | 29 | 49 | 34 | 33 | 35 | 25 | 19 | 38 | 327 | <=29 | >32 |
| Number of complaints per 1000 bed days | 1.86 | 1.91 | 1.34 | 1.80 | 1.83 | 1.36 | 1.44 | 2.46 | 1.73 | 1.67 | 1.71 | 1.22 | 0.93 | 1.79 | 1.61 | <=1.52 | >1.68 |
| % of complaints answered within 25 days | 69% | 95% | 96% | 73% | 69% | 86% | 90% | 80% | 88% | 83% | 78% | 84% | 100% | in arrears | 83% | >85% | <70% |
| Number of complaints re-opened | 10 | | | 10 | 3 | 4 | 6 | 2 | 0 | 1 | 0 | 0 | 0 | 1 | 17 | TBC | |
| **Friends and Family Scores - What % would recommend this trust to friends and family if they needed similar care or treatment?** | | | | | | | | | | | | | | | | | |
| Overall % (includes inpatients, A&E, outpatients, maternity and community services) ** | 90% | 94% | 93% | 93% | 93% | 93% | 95% | 94% | 95% | 94% | 95% | 95% | 94% | 95% | 94% | >=90% | <85% |

* Annual targets are as follows: Number of complaints (350)
** surveys include paediatrics and day surgery as from Apr-15 and community services from Jan-15

# Appendix - Caring - Key measures (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Local Surveys (trust-wide measures are being reviewed; a new trust-wide survey will commence in 2015/16)** | | | | | | | | | | | | | | | | | |
| 1. Overall did you feel you were treated with respect and dignity whilst in hospital? | New | | | | 92% (45/49) | 95% | 98% | 94% | 92% | 95% | 97% | 97% | 94% | 98% (164/168) | 96% | >=90% | <80% |
| 2. Were you given enough privacy on the ward? | New | | | | 96% (43/45) | 96% | 99% | 98% | 95% | 96% | 97% | 93% | 98% | 98% (163/167) | 96% | >=90% | <80% |
| 3. Do you have confidence and trust in the doctors treating you? | New | | | | 94% (46/49) | 85% | 96% | 92% | 79% | 89% | 89% | 90% | 88% | 92% (155/168) | 90% | >=90% | <80% |
| 4. Were you bothered by noise at night from staff? (percentage of patients saying no) | New | | | | 83% (40/48) | 90% | 90% | 87% | 84% | 88% | 88% | 93% | 94% | 89% (147/166) | 90% | >=80% | <70% |
| 5. Were you bothered by noise at night from other patients? (percentage of patients saying no) | New | | | | 83% (40/48) | 75% | 77% | 61% | 61% | 80% | 75% | 73% | 76% | 70% (117/166) | 74% | >=75% | <65% |
| 6. Have you noticed a difference in the quality of your care at different times of the day or week? | New | | | | 94% (45/48) | 85% | 94% | 83% | 89% | 90% | 89% | 90% | 91% | 92% (155/168) | 90% | >=90% | <80% |
| 7. Do you get enough help from staff to eat your meals? | New | | | | 47% (15/32) | 89% | 100% | 82% | 33% | 90% | 80% | 87% | 80% | 92% (24/26) | 83% | >=90% | <80% |
| 8. Do you feel that you and your family/carers have been involved in planning for your discharge from hospital? | New | | | | 44% (17/39) | 67% | 75% | 73% | 58% | 52% | 44% | 44% | 38% | 64% (83/129) | 53% | >=75% | <65% |
| 9. Did staff examining and treating for you introduce themselves? | New | | | | 50% (24/48) | 78% | 97% | 82% | 84% | 77% | 87% | 77% | 80% | 86% (142/166) | 81% | >=90% | <80% |
| **Complaints** | | | | | | | | | | | | | | | | | |
| Number of complaints received * | 570 | 39 | 43 | 39 | 39 | 29 | 31 | 32 | 24 | 38 | 28 | 24 | 16 | 33 | 294 | <=39 | >43 |
| Number of complaints per 1000 bed days | 2.81 | 2.19 | 2.77 | 2.27 | 2.43 | 1.75 | 1.97 | 2.08 | 1.46 | 2.28 | 1.63 | 1.47 | 0.98 | 1.89 | 1.79 | <=2.34 | >2.57 |
| % of complaints answered within 25 days | 13% | 15% | 19% | 13% | 18% | 41% | 45% | 31% | 21% | 26% | 43% | 46% | 50% | in arrears | 30% | >85% | <70% |
| Number of complaints re-opened | 132 | 8 | 7 | 3 | 4 | 9 | 1 | 6 | 7 | 2 | 6 | 0 | 4 | 3 | 42 | | |
| **Friends and Family Scores - What % would recommend this trust to friends and family if they needed similar care or treatment?** | | | | | | | | | | | | | | | | | |
| Overall % (includes inpatients, A&E, outpatients, maternity and community services) ** | 90% | 91% | 90% | 90% | 92% | 93% | 93% | 94% | 93% | 93% | 96% | 95% | 97% | 96% | 94% | >=90% | <85% |

* provisional data for the reporting month
** surveys include paediatrics and day surgery as from Apr-15 and community services from Jan-15
* Annual targets are as follows: Number of complaints (473)

# Appendix - Caring - What our patients are saying (FPH)

**Some of the positive feedback we have received:**

"I have been well looked after"
**Bourne Ward – Farnham Hospital**

"Absolutely superb care from both doctors and nurses"
**CCU**

"Quieter than other wards, easier to sleep"
**F9**

**Where can we improve:**

Comments fed back to the area concerned immediately for action if required. Trends reported to Patient Experience Forum monthly:

"They seemed to not pay attention to you"
**F4**

"Polite attentive staff, progress made every day. Until discharge delayed by hours owing to wait for drugs from pharmacy I was initially told were already on the ward. Staff seem to find this funny."
**AMU**

"Had some confusing/conflicting information. Too many staff changes. Otherwise the staff were kind and caring. I am forever in their debt."
**F7**

# Appendix - Caring - What our patients are saying (Heatherwood)

**Some of the positive feedback we have received:**

"Excellent care. The human touch was second to none. Compliant and caring staff made you feel relaxed and hopeful."

**Cardiology**

"Very very good service! Helpful, kind environment, walked through everything with me!"

**Pre operative Assessment**

"So very caring - Radiographer so kind I cannot praise them highly enough - was very nervous - put me at ease."

**Radiology**

**Where can we improve:**

Comments fed back to the area concerned immediately for action if required. Trends reported to Patient Experience Forum monthly:

"Why give 12.30 appointment for all 6 people at same time?"

**Day Surgery Unit**

"Lean towards likely on basis of great staff. Lean towards unlikely on basis on persistent delay ie operation was 5 hours delayed."

**Ward 4**

"Rather deaf so very difficult to take in so much information."

**Pre-operative Assessment**

# Appendix - Caring - What our patients are saying (Wexham Park)

**Some of the positive feedback we have received:**

"The staff here are very friendly and have well experiences. They manage to rebuild my confidence too."
**Amputee Therapy Service**

"Everything was explained and I was listened to when I stated what I would prefer to happen depending on the outcome of my appointment."
**Colposcopy Clinic**

"Unexpected service on-time. Friendly, professionals with clear advice for moving forward."
**Speech and Language Therapy**

**Where can we improve:**

Comments fed back to the area concerned immediately for action if required. Trends reported to Patient Experience Forum monthly:

"Don't like hospitals, as the waiting times are ridiculous and information given next to none."
**Ambulatory Care Unit**

"I waited for a long time to be seen only to be told that there is nothing there can be done. A young doctor kept running in and out to talk to a senior member."
**Children's Clinic**

"When you say you're going to call back you never do."
**Outpatients**

# Appendix - Responsive - Key measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Waiting lists** | | | | | | | | | | | | | | | | |
| Outpatient Total Waiting List | | 8581 | 7864 | 8162 | 9006 | 9890 | 9742 | 11044 | 11054 | 10901 | 11350 | 10563 | 10418 | 10863 | None | |
| Elective Total Waiting List | | 4448 | 4404 | 4234 | 4542 | 4742 | 4882 | 4979 | 5169 | 5229 | 5430 | 5733 | 5940 | 6005 | None | |
| **Diagnostics** | | | | | | | | | | | | | | | | |
| Diagnostics waiting 6 weeks and over | 2141 | 425 | 278 | 67 | 216 | 383 | 513 | 464 | 454 | 346 | 161 | 35 | 43 | 43 | None | |
| % waiting over 6 weeks and over for a diagnostic | 4.4% | 9.8% | 6.3% | 1.8% | 5.4% | 7.1% | 9.6% | 8.8% | 8.9% | 7.3% | 3.5% | 0.8% | 0.9% | 1.0% | <=1.0% | None |
| **Referral to treatment (RTT)** | | | | | | | | | | | | | | | | |
| RTT Total incomplete waiting list | | 14528 | 14501 | 14544 | 15345 | 16097 | 16039 | 17219 | 17217 | 17774 | 18599 | 18662 | 19088 | 20177 | *Targets and thresholds to be agreed in light of new RTT guidance* | |
| RTT waiting 18 weeks and over (backlog) | | 1001 | 927 | 806 | 701 | 672 | 822 | 1017 | 1302 | 1299 | 1286 | 1313 | 1473 | 1600 | | |
| RTT waiting 35 weeks and over | | 1 | 3 | 0 | 5 | 5 | 8 | 10 | 12 | 12 | 12 | 21 | 27 | 26 | | |
| RTT waiting 52 weeks and over | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

# Appendix - Responsive - Key measures (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Waiting lists** | | | | | | | | | | | | | | | | |
| Outpatient Total Waiting List | | 7063 | 7078 | 7507 | 7370 | 7845 | 7767 | 7439 | 7570 | 7571 | 7471 | 7223 | 7163 | 7409 | None | |
| Elective Total Waiting List | | 3072 | 3118 | 3009 | 3002 | 2972 | 2987 | 2911 | 2881 | 2995 | 3004 | 3259 | 3257 | 3147 | None | |
| **Diagnostics** | | | | | | | | | | | | | | | | |
| Diagnostics waiting 6weeks and over | 1338 | 246 | 173 | 83 | 31 | 42 | 5 | 0 | 1 | 0 | 1 | 2 | 4 | 9 | None | |
| % waiting over 6 weeks and over for a diagnostic | 2.4% | 5.0% | 3.5% | 1.6% | 0.6% | 0.9% | 0.1% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% | 0.2% | <=1.0 % | None |
| **Referral to treatment (RTT)** | | | | | | | | | | | | | | | | |
| RTT Total incomplete waiting list | | 10135 | 10196 | 10516 | 10372 | 10817 | 10754 | 10350 | 10451 | 10566 | 10475 | 10482 | 10420 | 10556 | *Targets and thresholds to be agreed in light of new RTT guidance* | |
| RTT waiting 18 weeks and over (backlog) | | 757 | 863 | 752 | 712 | 631 | 613 | 667 | 725 | 740 | 737 | 734 | 827 | 768 | | |
| RTT waiting 35 weeks and over | | 69 | 69 | 60 | 60 | 47 | 40 | 39 | 31 | 25 | 31 | 31 | 39 | 50 | | |
| RTT waiting 52 weeks and over | | 0 | 0 | 3 | 5 | 2 | 3 | 2 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | |

# Appendix - Responsive - Monitor dashboard (FPH)

| | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target | Weighting |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clostridium difficile** | | | | | | | | | | | | | | | | | | | |
| Total Clostridium difficile Cases | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 5 | 5 | 4 | 0 | 9 | 0 | | |
| Clostridium difficile Due To Lapses In Care | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 2 | 2 | 3 | 0 | 5 | 0 | 11 | 1.0 |
| **A&E** | | | | | | | | | | | | | | | | | | | |
| % Seen Within 4 hours | 92.1% | 95.3% | 95.1% | 94.1% | 93.5% | 95.2% | 96.7% | 95.1% | 96.4% | 95.9% | 93.1% | 95.1% | 95.3% | 94.6% | 95.3% | 95.1% | 90.9% | 95% | 1.0 |
| **RTT Waiting Times*** | | | | | | | | | | | | | | | | | | | |
| % treated within 18wks – admitted | 90.4% | 90.7% | 87.5% | 87.5% | 91.9% | 92.2% | 90.5% | 91.5% | 86.5% | 82.6% | 76.7% | 76.7% | 73.7% | 73.8% | 77.9% | 73.7% | 72.9% | 90% | 1.0 |
| % treated within 18wks – non-admitted | 95.8% | 95.7% | 96.1% | 95.9% | 95.8% | 96.1% | 95.0% | 95.5% | 95.1% | 88.5% | 82.1% | 82.1% | 82.0% | 83.1% | 85.0% | 82.0% | 78.8% | 95% | 1.0 |
| % waiting within 18wks - incomplete pathways | 94.4% | 94.9% | 95.6% | 95.0% | 95.4% | 95.8% | 94.9% | 95.4% | 94.7% | 92.4% | 92.7% | 93.2% | 93.1% | 93.0% | 92.3% | 92.8% | 92.1% | 92% | 1.0 |
| **Cancer** | | | | | | | | | | | | | | | | | | | |
| 2 week waits – urgent GP referrals | 95.2% | 96.0% | 96.3% | 95.9% | 96.1% | 96.4% | 95.0% | 95.8% | 92.9% | 95.3% | 94.7% | 94.3% | 94.7% | 94.9% | 95.4% | 95.0% | in arrears | 93% | 1.0 |
| 2 week waits - Breast symptomatic referrals | 93.2% | 96.7% | 98.5% | 96.3% | 97.9% | 98.3% | 97.2% | 97.8% | 96.0% | 91.3% | 92.2% | 93.1% | 96.9% | 89.1% | 96.0% | 93.8% | in arrears | 93% | |
| 31 day wait for first treatment | 98.8% | 100% | 97.8% | 98.8% | 98.9% | 98.8% | 98.1% | 98.8% | 100% | 97.6% | 98.9% | 99.0% | 99.0% | 100% | 98.2% | 99.1% | in arrears | 96% | 1.0 |
| 31 day wait for second or subsequent treatment – Surgery | 100% | 93.8% | 100% | 97.6% | 100% | 100% | 88.9% | 96.6% | 100% | 84.6% | 100% | 100% | 100% | 100% | 90.0% | 97.3% | in arrears | 94% | 1.0 |
| 31 day wait for second or subsequent treatment – Anti cancer drugs | 100% | 100% | 100% | 100% | NA | NA | NA | NA | 100% | NA | 100% | 100% | 100% | NA | 100% | 100% | in arrears | 98% | |
| 62 day wait for first treatment | 87.8% | 88.9% | 87.3% | 87.3% | 86.9% | 81.1% | 86.7% | 85.2% | 86.5% | 93.0% | 85.7% | 88.3% | 86.2% | 81.5% | 89.5% | 86.1% | in arrears | 85% | 1.0 |
| 62 day wait for screening patients | 100% | 66.7% | 83.3% | 84.2% | 100% | 100% | 85.7% | 93.8% | 100% | 100% | 100% | 100% | 100% | 100% | 90.0% | 94.3% | in arrears | 90% | |
| **Overall performance score** | | | | | | | | | | | | | | | | | | | |
| Service Performance Score | | | | 3 | | | | 0 | | | | 0 | | | | 1 | | | |

**RTT Waiting Times (Admitted and Non-Admitted) are not RAG rated and not included in scoring from Jul-15 onwards as these are no longer national targets*
*NA – Not Applicable*

# Appendix - Responsive - Monitor dashboard (HWP)

| | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep-15 | Q2 | Oct | Nov | Dec-15 | Q3 | Jan-16 | Target | Weighting |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clostridium difficile** | | | | | | | | | | | | | | | | | | | |
| Total Clostridium difficile Cases | 3 | 2 | 1 | 6 | 3 | 1 | 2 | 6 | 5 | 3 | 4 | 12 | 1 | 0 | 2 | 3 | 1 | | |
| Clostridium difficile Due To Lapses In Care | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 20 | 1.0 |
| **A&E** | | | | | | | | | | | | | | | | | | | |
| % Seen Within 4 hours | 89.6% | 96.4% | 95.2% | 93.5% | 97.7% | 97.5% | 96.8% | 97.4% | 96.9% | 95.6% | 94.3% | 95.6% | 94.3% | 97.3% | 96.8% | 96.1% | 93.6% | 95% | 1.0 |
| **RTT Waiting Times** | | | | | | | | | | | | | | | | | | | |
| % treated within 18wks – admitted | 91.2% | 88.9% | 85.4% | 85.4% | 90.2% | 91.5% | 92.0% | 91.3% | 91.1% | 87.9% | 90.2% | 87.9% | 86.9% | 85.9% | 89.5% | 85.9% | 83.7% | 90% | 1.0 |
| % treated within 18wks – non-admitted | 95.1% | 95.1% | 95.1% | 95.1% | 95.1% | 95.1% | 95.5% | 95.3% | 95.3% | 95.2% | 94.3% | 94.3% | 93.5% | 93.0% | 92.9% | 92.9% | 92.6% | 95% | 1.0 |
| % waiting within 18wks - incomplete pathways | 92.5% | 91.5% | 92.8% | 91.5% | 93.2% | 94.2% | 94.3% | 93.9% | 93.6% | 93.1% | 93.0% | 93.2% | 93.0% | 93.0% | 92.1% | 92.7% | 92.7% | 92% | 1.0 |
| **Cancer** | | | | | | | | | | | | | | | | | | | |
| 2 week waits – urgent GP referrals | 93.3% | 96.2% | 95.7% | 95.1% | 91.1% | 95.1% | 96.5% | 94.2% | 96.2% | 95.5% | 93.6% | 94.8% | 95.6% | 97.3% | 96.4% | 96.5% | in arrears | 93% | 1.0 |
| 2 week waits - Breast symptomatic referrals | 99.1% | 100% | 100% | 99.8% | 96.2% | 96.9% | 97.2% | 96.8% | 98.6% | 95.3% | 93.9% | 95.5% | 98.3% | 98.6% | 99.1% | 98.7% | in arrears | 93% | |
| 31 day wait for first treatment | 100% | 100% | 100% | 100% | 100% | 98.3% | 100% | 99.5% | 98.6% | 100% | 100% | 99.5% | 100% | 100% | 100% | 100% | in arrears | 96% | 1.0 |
| 31 day wait for second or subsequent treatment – Surgery | 100% | 100% | 96.7% | 98.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | in arrears | 94% | 1.0 |
| 31 day wait for second or subsequent treatment – Anti-cancer drugs | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | in arrears | 98% | |
| 62 day wait for first treatment | 80.6% | 89.0% | 85.7% | 85.0% | 89.2% | 89.0% | 98.1% | 91.9% | 88.5% | 91.8% | 85.5% | 88.2% | 86.7% | 90.3% | 96.0% | 90.8% | in arrears | 85% | 1.0 |
| 62 day wait for screening patients | 73.9% | 100% | 100% | 90.3% | 100% | 93.5% | 100% | 98.0% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | in arrears | 90% | |
| **Overall performance score** | | | | | | | | | | | | | | | | | | | |
| Service Performance Score | | | | 3 | | | | 0 | | | | 0 | | | | 0 | | | |

**RTT Waiting Times (Admitted and Non-Admitted) are not RAG rated and not included in scoring from Jul-15 onwards as these are no longer national targets*

# Appendix - Responsive – Cancer 62-day waits standard by tumour group (FPH)

| | Dec-14 | Q3 | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain/CNS | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | In arrears | >=85% |
| Breast | 80.0% | 96.1% (24.5/25.5) | 100% | 100% | 100% | 100% (24.5/24.5) | 100% | 100% | 100% | 100% (31/31) | 100% | 100% | 100% | 100% (39/39) | 100% | 100% | 100% | 100% (35/35) | | |
| Childrens | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| Gynaecological | 87.5% | 56.5% (6.5/11.5) | 100% | 75.0% | 88.9% | 85.7% (6/7) | 100% | 60.0% | 100% | 80.0% (4/5) | 71.4% | 100% | 25% | 68.8% (5.5/8) | 83.3% | 66.7% | 75.0% | 78.9% (7.5/9.5) | | |
| Haematological | 66.7% | 80.0% (8/10) | 80.0% | 66.7% | 66.7% | 66.7% (8/12) | NA | 100% | 50.0% | 66.7% (2/3) | 0.0% | 100% | NA | 50.0% (3/6) | 85.7% | 16.7% | 100% | 59.3% (8/13.5) | | |
| Head & Neck | 0.0% | 50.0% (1.5/3) | 100% | NA | 0.0% | 25.0% (0.5/2) | 100% | NA | 0.0% | 75.0% (1.5/2) | 100% | 33.3% | 0% | 44.4% (2/4.5) | 33.3% | 50.0% | 0.0% | 33.3% (1/3) | | |
| Lower GI | 100% | 94.7% (9/9.5) | 75.0% | 80.0% | 100% | 90.0% (9/10) | 85.7% | 81.3% | 91.7% | 85.7% (18/21) | 100% | 80.0% | 75% | 89.7% (13/14.5) | 66.7% | 57.1% | 82.4% | 72.7% (12/16.5) | | |
| Lung | NA | 100% (1/1) | 100% | 100% | 33.3% | 80.0% (4/5) | NA | 66.7% | 100% | 77.8% (3.5/4.5) | 100% | 100% | 75% | 86.4% (9.5/11) | 55.6% | 100% | 100% | 75.0% (6/8) | | |
| Sarcomas | NA | NA | NA | 50.0% | 75.0% | 71.4% (2.5/3.5) | NA | NA | 100% | 100% (0.5/0.5) | NA | NA | NA | NA | 100% | NA | NA | 100% (1/1) | | |
| Skin | 100% | 95.7% (22.5/23.5) | 100% | 100% | 92.3% | 96.4% (27/28) | 100% | 100% | 87.5% | 94.9% (37/39) | 100% | 100% | 100% | 98.4% (31/31.5) | 100% | 93.9% | 100% | 97.8% (44.5/45.5) | | |
| Upper GI | 100% | 80.0% (4/5) | 60.0% | 80.0% | 85.7% | 76.5% (6.5/8.5) | 63.6% | 66.7% | 60.0% | 70.6% (6/8.5) | 66.7% | 50.0% | 50.0% | 69.2% (4.5/6.5) | 100% | 100% | 0.0% | 90.9% (5/5.5) | | |
| Urological | 100% | 92.9% (26/28) | 80.0% | 88.2% | 93.8% | 87.5% (21/24) | 75.0% | 57.1% | 66.7% | 65.0% (19.5/30) | 70.0% | 88.2% | 100% | 85.2% (23/27) | 73.3% | 88.0% | 78.3% | 81.0% (25.5/31.5) | | |
| Other | 0.0% | 0.0% (0/0.5) | 50.0% | NA | NA | 50.0% (0.5/1) | 100% | NA | 100% | 100% (1/1) | NA | NA | 100% | 100% (1/1) | NA | 100% | NA | 100% (0.5/0.5) | | |
| Total | **88.1%** | **87.7% (103/117.5)** | **87.8%** | **88.9%** | **87.3%** | **87.3% (107/122)** | **86.9%** | **81.1%** | **86.7%** | **85.2% (123.5/145)** | **86.5%** | **93.0%** | **85.7%** | **88.3% (131.5/149)** | **86.2%** | **81.5%** | **89.5%** | **86.1% (145/168.5)** | | |
| **Cancer – 62-day referral to treatment standard – over 104 day waiters** | | | | | | | | | | | | | | | | | | | | |
| Number of Patients waiting over 104 days | | | | | | | | | | | 13 | 14 | 15 | | 12 | 13 | 19 | | 10 | |
| % of patients waiting over 104 days | | | | | | | | | | | 1.6% | 1.6% | 2.6% | | 2.2% | 2.0% | 3.0% | | 2.1% | |

*Half numbers are where a patient has been referred here for treatment from another provider or vice versa; the patient is shared between providers*
*The additional figures provided for the quarters are the number of patients treated within the 62-day standard out of the total number of patients treated for that tumour group*

# Appendix - Responsive – Cancer 62-day waits standard by tumour group (HWP)

| | Dec-14 | Q3 | Jan-15 | Feb | Mar | Q4 | Apr | May | Jun | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain/CNS | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| Breast | 100% | 94.1% (40/42.5) | 100% | 100% | 100% | 100% (42.5/42.5) | 100% | 100% | 96.6% | 98.5% (32/32.5) | 100% | 100% | 100% | 100% | 100% | 78.9% | 100% | 94.1% (32/34) | | |
| Childrens | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | | |
| Gynaecological | 77.8% | 69.2% (4.5/6.5) | 0.0% | 83.3% | 50.0% | 56.3% (4.5/8) | 50.0% | 100% | NA | 71.4% (2.5/3.5) | 66.7% | 85.7% | 66.7% | 76.9% (5/6.5) | 100% | 100% | 100% | 100% (4.5/4.5) | | |
| Haematological | 100% | 83.3% (5/6) | 33.3% | 100% | 71.4% | 64.7% (5.5/8.5) | 100% | 100% | 100% | 100% (4/4) | 100% | 57.1% | 71.4% | 77.4% (12/15.5) | 50.0% | 100% | 100% | 76.9% (10/13) | | |
| Head & Neck | 75.0% | 76.5% (6.5/8.5) | NA | 50.0% | 0.0% | 28.6% (1/3.5) | 66.7% | 57.1% | 100% | 71.4% (5/7) | NA | 80.0% | 100% | 83.3% (2.5/3) | NA | 57.1% | 50.0% | 54.5% (3/5.5) | | |
| Lower GI | 88.9% | 79.5% (17.5/22) | 90.5% | 100% | 93.3% | 93.5% (21.5//23) | 100% | 100% | 100% | 100% (13.5/13.5) | 100% | 100% | 100% | 100% (11/11) | 100% | 100% | 100% | 100% (17/17) | In arrears | >=85% |
| Lung | 100% | 87.5% (10.5/12) | 100% | 50.0% | 100% | 86.7% (6.5/7.5) | 100% | 50.0% | 66.7% | 78.6% (5.5/7) | 66.7% | 100% | 62.5% | 76.9% (10/13) | 90.9% | 90.0% | 100% | 91.3% (10.5/11.5) | | |
| Sarcomas | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | 100% | NA | NA | NA | | |
| Skin | 100% | 100% (27/27) | 100% | 100% | 100% | 100% (27/27) | 100% | 100% | 100% | 100% (31.5/31.5) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% (35/35) | | |
| Upper GI | 100% | 85.2% (11.5/13.5) | 60.0% | 100% | 100% | 88.2% (7.5/8.5) | 75.0% | 83.3% | 100% | 87.1% (13.5/15.5) | 100% | 75.0% | NA | 87.5% (7/8) | 33.3% | 100% | 100% | 81.8% (9/11) | | |
| Urological | 54.5% | 60.9% (28/46) | 66.7% | 77.3% | 50.0% | 65.2% (22.5/34.5) | 83.9% | 87.0% | 100% | 88.1% (55.5/63) | 65.0% | 93.3% | 65.6% | 70.0% (31.5/45) | 79.3% | 85.7% | 92.3% | 86.4% (38/44) | | |
| Other | 0.0% | 0.0% (0/1) | NA | NA | 100% | 100% (0.5/0.5) | 100% | NA | NA | 100% (1/1) | NA | NA | 100% | 100% (1/1) | NA | 100% | 100% | 100% (3/3) | | |
| Total | **82.6%** | **81.4% (150.5/185)** | **80.6%** | **89.0%** | **85.7%** | **85.0% (139/163.5)** | **89.2%** | **89.0%** | **98.1%** | **91.9% (164/178.5)** | **88.5%** | **91.8%** | **85.5%** | **88.2% (172/195)** | **86.7%** | **90.3%** | **96.0%** | **90.8% (162/178.5)** | | |
| **Cancer – 62-day referral to treatment standard – over 104 day waiters** | | | | | | | | | | | | | | | | | | | | |
| Number of Patients waiting over 104 days | | | | | | | | | | | 2 | 3 | 3 | | 3 | 3 | 2 | | 3 | |
| % of patients waiting over 104 days | | | | | | | | | | | 0.3% | 0.5% | 0.5% | | 0.5% | 0.4% | 0.3% | | 0.5% | |

*Half numbers are where a patient has been referred here for treatment from another provider or vice versa; the patient is shared between providers*
*The additional figures provided for the quarters are the number of patients treated within the 62-day standard out of the total number of patients treated for that tumour group*

# Appendix - Workforce - Key measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff numbers** | | | | | | | | | | | | | | | | | |
| Staff in Post FTE | N/A | 3934 | 3941 | 3959 | 3969 | 3970 | 4000 | 4019 | 3989 | 4023 | 4031 | 4052 | 4064 | 4096 | N/A | N/A | N/A |
| Vacancy FTE | N/A | 249 | 249 | 218 | 373 | 375 | 356 | 338 | 352 | 332 | 357 | 343 | 352 | 326 | N/A | N/A | N/A |
| Starters FTE | 664 | 53 | 44 | 54 | 50 | 33 | 46 | 55 | 39 | 67 | 58 | 53 | 49 | 55 | 504 | N/A | N/A |
| Leavers FTE | 646 | 30 | 39 | 50 | 38 | 38 | 33 | 51 | 37 | 66 | 55 | 45 | 39 | 54 | 458 | N/A | N/A |
| **Turnover rate *** | | | | | | | | | | | | | | | | | |
| Turnover % | 13.2% | 13.2% | 13.3% | 13.1% | 12.7% | 13.3% | 13.0% | 13.2% | 11.8% | 11.8% | 12.2% | 12.3% | 11.5% | 11.9% | 12.9% | <=12.0% | >13.5% |
| **Vacancy rate **** | | | | | | | | | | | | | | | | | |
| Vacancy % | N/A | 6.8% | 6.4% | 5.5% | 9.1% | 9.1% | 8.7% | 8.2% | 8.6% | 8.1% | 8.6% | 8.2% | 8.4% | 7.8% | N/A | <=8.5% | >10.0% |
| **Sickness absence rate *** | | | | | | | | | | | | | | | | | |
| Sickness Absence Rate % | 3.0% | 3.3% | 3.3% | 3.0% | 2.8% | 2.8% | 2.4% | 2.5% | 2.7% | 2.9% | 3.2% | 3.1% | 3.0% | 3.1% | 3.0% | <=2.9% | >3.2% |
| **Appraisal rates** | | | | | | | | | | | | | | | | | |
| Appraisal (non Medical) % | N/A | 59% | 56% | 56% | 45% | *** | | | | 30% | 33% | 34.0% | 32.0% | 36.0% | N/A | >=80% | <70% |
| Appraisal (Medical) % | N/A | | | | 92.8% | 95.3% | 94.2% | 94.2% | 96.6% | 95.7% | 92.1% | 92.3% | 91.2% | 92.4% | N/A | >=80% | <70% |
| **Friends & family test for staff - % recommending here as a place to work** | | | | | | | | | | | | | | | | | |
| Staff FFT | N/A | 75.4% | | | 66.2% | | | 73.7% | | | | | | | | N/A | N/A |

*Targets amended in Aug 2015 and applied retrospectively to Turnover and Vacancy rates*
** "YTD" figures for turnover and sickness absence are the average performance over the past 12 months*
*** Budgets for 2015/16 have been aligned with ESR in July 2015 providing a more comprehensive position for vacancies at FPH. This has been applied retrospectively from April 2015*
**** The appraisal trackers were taken off-line in June 2015 to develop them from the legacy organisations to reflect the new structure of Frimley Health. The development work was completed and the trackers made live again in September 2015*

# Appendix - Workforce - Key measures (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff numbers** | | | | | | | | | | | | | | | | | |
| Staff in Post FTE | N/A | 3565 | 3560 | 3517 | 3505 | 3500 | 3493 | 3483 | 3481 | 3474 | 3499 | 3471 | 3449 | 3440 | N/A | N/A | N/A |
| Vacancy FTE | N/A | 537 | 521 | 467 | 587 | 591 | 598 | 608 | 603 | 611 | 595 | 620 | 607 | 662 | N/A | N/A | N/A |
| Starters FTE | 849 | 62 | 60 | 39 | 34 | 45 | 41 | 30 | 39 | 60 | 92 | 41 | 43 | 54 | 481 | N/A | N/A |
| Leavers FTE | 836 | 59 | 60 | 71 | 62 | 46 | 36 | 50 | 48 | 60 | 57 | 57 | 22 | 36 | 475 | N/A | N/A |
| **Turnover rate** | | | | | | | | | | | | | | | | | |
| Turnover % | 14.0% | 18.5% | 13.5% | 14.0% | 17.9% | 18.0% | 17.7% | 17.6% | 17.6% | 17.3% | 17.6% | 17.9% | 18.0% | 17.6% | 16.9% | <=17.0% | >18.5% |
| **Vacancy rate** * | | | | | | | | | | | | | | | | | |
| Vacancy % | N/A | 11.7% | 11.9% | 11.7% | 15.0% | 15.1% | 15.2% | 15.5% | 15.4% | 15.6% | 15.1% | 15.7% | 16.2% | 16.8% | N/A | <=15.0% | >16.5% |
| **Sickness absence rate** * | | | | | | | | | | | | | | | | | |
| Sickness Absence Rate % | 3.5% | 3.8% | 3.4% | 3.2% | 3.2% | 3.1% | 3.5% | 3.6% | 3.4% | 3.1% | 3.4% | 2.9% | 3.2% | 2.9% | 3.4% | <=2.9% | >3.2% |
| **Appraisal rates** | | | | | | | | | | | | | | | | | |
| Appraisal (non Medical) % | N/A | 48% | 47% | 47% | 39% | ** | | | | 25% | 28% | 30% | 30.0% | 29.0% | N/A | >=80.0% | <70.0% |
| Appraisal (Medical) % | N/A | | | | 91.7% | 92.2% | 88.1% | 88.4% | 88.7% | 87.5% | 85.8% | 83% | 82.3% | 82.3% | N/A | >=80.0% | <70.0% |
| **Friends & family test for staff - % recommending here as a place to work** | | | | | | | | | | | | | | | | | |
| Staff FFT | N/A | 51.7% | | | 48.9% | | | 55.5% | | | | | | | | N/A | N/A |

*Targets amended in Aug 2015 and applied retrospectively for Turnover and Vacancy rates*
** "YTD" figures for turnover and sickness absence are the average performance over the past 12 months*
*** The appraisal trackers were taken off-line in June 2015 to develop them from the legacy organisations to reflect the new structure of Frimley Health. The development work was completed and the trackers made live again in September 2015*

# Appendix - Efficiency – Efficiency Key measures (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatients **** | | | | | | | | | | | | | | | | | |
| Did not attend (DNA) rates | 5.7% | 5.7% | 5.2% | 5.2% | 5.2% | 5.3% | 5.4% | 5.2% | 5.3% | 5.6% | 5.0% | 5.1% | 5.4% | 5.7% | 5.3% | <=7.9% | >10.4% |
| Outpatient follow-up ratios | 2.01 | 2.09 | 2.00 | 2.09 | 2.11 | 2.08 | 2.02 | 2.02 | 2.02 | 2.09 | 2.04 | 1.92 | 2.03 | 2.05 | 2.04 | <=2.12 | >3.30 |
| **Average Length of stay *** | | | | | | | | | | | | | | | | | |
| Elective length of stay | 2.71 | 2.76 | 2.67 | 2.92 | 2.79 | 2.92 | 2.35 | 2.46 | 2.55 | 2.46 | 2.78 | 2.66 | 2.52 | 2.45 | 2.60 | <=2.93 | >3.71 |
| Non-elective length of stay | 4.14 | 4.45 | 4.26 | 3.99 | 4.34 | 4.13 | 4.35 | 4.03 | 4.07 | 4.24 | 3.97 | 4.23 | 4.16 | 4.27 | 4.18 | <=4.73 | >6.19 |
| **Day case rate **** | | | | | | | | | | | | | | | | | |
| % day cases of all electives | 84% | 86% | 83% | 84% | 82% | 81% | 82% | 83% | 83% | 85% | 81% | 82% | 83% | 84% | 83% | >=77% | <67% |

** The targets and thresholds for the average length of stay measures have been adjusted to reflect the activity and specialty mix trust-wide and for each site from September 2015 and applied retrospectively*

*** The targets and thresholds for the outpatient measures and the day case rate have been adjusted to reflect the activity and specialty mix trust-wide and for each site from November 2015 and applied retrospectively*

# Appendix - Efficiency – Efficiency Key measures (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatients **** | | | | | | | | | | | | | | | | | |
| Did not attend (DNA) rates | 8.1% | 8.1% | 7.4% | 7.7% | 8.0% | 8.2% | 7.7% | 8.0% | 8.5% | 8.0% | 7.5% | 7.5% | 8.0% | 7.6% | 7.9% | <=7.5% | >9.9% |
| Outpatient follow-up ratios | 2.33 | 2.38 | 2.39 | 2.42 | 2.43 | 2.43 | 2.36 | 2.30 | 2.32 | 2.31 | 2.36 | 2.33 | 2.45 | 2.39 | 2.37 | <=2.14 | >3.30 |
| **Average Length of stay *** | | | | | | | | | | | | | | | | | |
| Elective length of stay | 2.38 | 2.06 | 2.38 | 2.17 | 2.34 | 2.22 | 2.43 | 1.98 | 2.28 | 2.97 | 2.85 | 2.40 | 2.63 | 1.97 | 2.41 | <=2.49 | >3.08 |
| Non-elective length of stay | 4.21 | 4.48 | 4.52 | 4.09 | 4.09 | 4.10 | 4.32 | 4.21 | 3.82 | 4.08 | 4.04 | 4.23 | 3.81 | 3.67 | 4.03 | <=3.22 | >4.14 |
| **Day case rate **** | | | | | | | | | | | | | | | | | |
| % day cases of all electives | 76% | 76% | 75% | 74% | 77% | 78% | 76% | 78% | 77% | 77% | 78% | 78% | 78% | 78% | 77% | >=80% | <70% |

** The targets and thresholds for the average length of stay measures have been adjusted to reflect the activity and specialty mix trust-wide and for each site from September 2015 and applied retrospectively*

*** The targets and thresholds for the outpatient measures and the day case rate have been adjusted to reflect the activity and specialty mix trust-wide and for each site from November 2015 and applied retrospectively*

# Appendix - CQUIN - National CQUIN performance (FPH)

| | 14/15 | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target | Total value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Acute kidney injury CQUIN** | | | | | | | | | | | | | |
| The percentage of key items included in the reviewed AKI discharge summaries | New | Achieved | 30% | 50% | 52% | 44% | 55% | 75% | 63% | 64% | | Q1 - n/a<br>Q2 - 30%<br>Q3 - 60%<br>Q4 - 90% | £533,493 |
| **Sepsis CQUIN** | | | | | | | | | | | | | |
| The percentage of patients who met the criteria of the local protocol for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate (Part 1) | New | Achieved | 100% | 100% | 75% | 92% | 100% | 100% | 100% | 100% | | Q1 - n/a<br>Q2 - 60%<br>Q3 - 75%<br>Q4 - 90% | £266,746 |
| The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies, and were administered intravenous antibiotics within 1 hour of arrival (Part 2) | New | Achieved | 85% | 63% | 78% | 74% | 79% | 70% | 77% | 76% | | Q1 - n/a<br>Q2 - n/a<br>Q3 - 70%<br>Q4 - 90% | £266,746 |
| **Dementia Care CQUIN** | | | | | | | | | | | | | |
| % of all admitted patients (75+) who have been screened for Dementia (within 72 hours) | 99% | Achieved | 99% | 99% | 100% | 99% | 99% | 100% | 98% | | 100% | >=90% | £320,097 |
| % of all admitted patients (75+) who scored positively on the dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) | 100% | Achieved | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | 100% | >=90% | |
| % of all admitted patients (75+) who received a dementia diagnostic assessment with a "positive" or "inconclusive" outcome that were then referred for further diagnostic advice/follow up (within 72 hours) | 100% | Achieved | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | 100% | >=90% | |
| Quarter 4 audit | New | NA | Not required in Q2 | | | NA | Not required in Q3 | | | NA | | TBC | |
| Delivery of dementia training programme (Level one only) – staff trained to date | New | Achieved | | | | Achieved | | | | Achieved | | 70% by Q4 * | £53,349 |
| Dementia carers survey undertaken each month | New | Achieved | | | | Achieved | | | | Achieved | | | £160,048 |
| **Ambulatory Care CQUIN** | | | | | | | | | | | | | |
| Ambulatory care | New | Achieved | | | | Achieved | | | | Achieved | | TBC * | £1,066,985 |

** Target proposal sent to CCG for agreement*

# Appendix - CQUIN - National CQUIN performance (HWP)

| | 14/15 | Q1 | Jul | Aug | Sep | Q2 | Oct | Nov | Dec | Q3 | Jan-16 | Target | Total value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Acute kidney injury CQUIN** | | | | | | | | | | | | | |
| The percentage of key items included in the reviewed AKI discharge summaries | New | Achieved | 20% | 30% | 25% | Achieved | 59% | 44% | 66% | 56.3% | | Q1 - n/a<br>Q2 - TBC<br>Q3 - TBC<br>Q4 - 90% | £500,000 |
| **Sepsis CQUIN** | | | | | | | | | | | | | |
| The percentage of patients who met the criteria of the local protocol for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate (Part 1) | New | Achieved | 54% | 61% | 72% | Achieved | 85% | 88% | 84% | 86% | | Q1 - n/a<br>Q2 - TBC<br>Q3 - TBC<br>Q4 - 90% | £250,000 |
| The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies, and were administered intravenous antibiotics within 1 hour of arrival (Part 2) | New | Achieved | 68% | 88% | 64% | Achieved | 64% | 79% | 79% | 74% | | Q1 - n/a<br>Q2 - n/a<br>Q3 - TBC<br>Q4 - 90% | £250,000 |
| **Dementia Care CQUIN** | | | | | | | | | | | | | |
| % of all admitted patients (75+) who have been screened for Dementia (within 72 hours) | 92% | | 94% | 96% | 91% | Achieved | 91% | 90% | 91% | | 93% | >=90% | |
| % of all admitted patients (75+) who scored positively on the dementia screening tool that then received a dementia diagnostic assessment (within 72 hours) | 92% | Achieved | 91% | 92% | 91% | Achieved | 92% | 100% | 97% | Achieved | 91% | >=90% | £300,000 |
| % of all admitted patients (75+) who received a dementia diagnostic assessment with a "positive" or "inconclusive" outcome that were then referred for further diagnostic advice/follow up (within 72 hours) | 100% | | 100% | 100% | 100% | Achieved | 100% | 100% | 100% | | 100% | >=90% | |
| Quarter 4 audit | New | NA | Not required in Q2 | | | NA | Not required in Q3 | | | NA | | TBC | |
| Delivery of dementia training programme (Level one only) – staff trained to date | New | | | | | | | | | | | TBC | £50,000 |
| Dementia carers survey undertaken each month | New | Achieved | | | | Achieved | | | | Achieved | | No target | £150,000 |
| **Ambulatory Care CQUIN** | | | | | | | | | | | | | |
| Ambulatory care | New | Achieved | | | | Achieved | | | | Achieved | | TBC | £1,000,000 |

# Appendix - CQUIN – Local CQUIN performance (FPH)

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Safer Transfer of Care** | | | | |
| Q3 Milestones<br><br>Complete discharge summary audit for each identified speciality<br>Carry out a Root Cause Analysis on 10 re-admissions cases<br>Training and education<br>Report to steering group | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |
| **Trusted Assessors** | | | | |
| Q3 Milestones<br><br>Complaints report to identify any carers concerns - including themes and actions<br>Carers questionnaire<br>Staff and Carers Awareness Campaign | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |
| **Carers as Partners in Care** | | | | |
| Q3 Milestones<br><br>Progress report on implementation of assessment and score | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |
| **Frail Elderly** | | | | |
| Q3 Milestones<br><br>Progress report on project and activity<br>Evidence of assessments | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |

# Appendix - CQUIN – Local CQUIN performance (HWP)

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Safer Transfer of Care** | | | | |
| Q3 Milestones<br><br>Audit of Discharge Summaries<br>Training plan update<br>Steering group report<br>RCA of re-admissions | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |
| **Trusted Assessors** | | | | |
| CLOSED DOWN | ACHIEVED | ACHIEVED | Closed Down – value reassigned | Not Due |
| **Carers as Partners in Care** | | | | |
| Q3 Milestones<br><br>Progress report | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |
| **Frail Elderly** | | | | |
| Q3 Milestones<br><br>Progress report on implementation of assessment and score | ACHIEVED | ACHIEVED | ACHIEVED | Not Due |

# Appendix - Activity (FPH)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | YTD % change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GP and general dental practitioner referrals to all outpatients** | | | | | | | | | | | | | | | | |
| NHS North East Hampshire & Farnham | 38769 | 3064 | 3153 | 3664 | 3146 | 3097 | 3192 | 3427 | 2775 | 3720 | 3963 | 3553 | 3135 | 3440 | 33448 | 5% |
| NHS Surrey Heath | 17204 | 1383 | 1359 | 1470 | 1427 | 1346 | 1513 | 1517 | 1215 | 1458 | 1479 | 1407 | 1271 | 1326 | 13959 | -3% |
| NHS Bracknell & Ascot | 8631 | 694 | 666 | 824 | 738 | 676 | 683 | 676 | 691 | 775 | 899 | 799 | 635 | 825 | 7397 | 4% |
| Other | 13611 | 1143 | 1070 | 1196 | 1129 | 1008 | 1086 | 1154 | 945 | 1190 | 1320 | 1238 | 977 | 1168 | 11215 | -1% |
| Total | 78215 | 6284 | 6248 | 7154 | 6440 | 6127 | 6474 | 6774 | 5626 | 7143 | 7661 | 6997 | 6018 | 6759 | 66019 | 2% |
| % change on previous year | | -4% | 1% | 9% | 3% | -10% | -3% | -4% | 1% | 7% | 6% | 9% | 4% | 8% | | |
| **Outpatient attendances** | | | | | | | | | | | | | | | | |
| New attendances | 164126 | 13519 | 13299 | 14011 | 13118 | 12342 | 14719 | 14430 | 12199 | 14100 | 14241 | 14861 | 13090 | 13474 | 136574 | 0% |
| Follow-up attendances | 329460 | 28322 | 26604 | 29259 | 27636 | 25665 | 29735 | 29174 | 24665 | 29471 | 29012 | 28535 | 26634 | 27636 | 278163 | 2% |
| Total OP attendances | 493586 | 41841 | 39903 | 43270 | 40754 | 38007 | 44454 | 43604 | 36864 | 43571 | 43253 | 43396 | 39724 | 41110 | 414737 | 1% |
| % change on previous year | | -3% | 7% | 8% | 5% | -4% | 5% | 0% | 3% | -1% | -3% | 6% | 2% | -2% | | |
| **A&E attendances** | | | | | | | | | | | | | | | | |
| A&E attendances (total) | 109109 | 8174 | 7917 | 9330 | 9037 | 9477 | 9503 | 9531 | 9005 | 9202 | 9446 | 9387 | 9150 | 9340 | 93078 | 1% |
| % change on previous year | | 0% | 3% | 1% | 4% | -4% | -3% | -2% | 2% | -1% | 1% | 5% | 1% | 14% | | |
| **Non-elective admissions** | | | | | | | | | | | | | | | | |
| Non-elective admissions (total) | 45301 | 3987 | 3555 | 4069 | 3789 | 3911 | 3877 | 4110 | 3771 | 3962 | 3953 | 3975 | 4182 | 4073 | 39603 | 5% |
| % change on previous year | | 11% | 11% | 12% | 7% | 6% | 11% | 10% | 5% | 5% | -2% | 6% | 3% | 2% | | |
| **Elective admissions** | | | | | | | | | | | | | | | | |
| Daycase | 40404 | 3732 | 3463 | 3957 | 2972 | 2788 | 3370 | 3501 | 2828 | 3627 | 3421 | 3146 | 3078 | 3441 | 32172 | -2% |
| Overnight | 7674 | 591 | 691 | 765 | 662 | 643 | 727 | 692 | 566 | 645 | 805 | 706 | 633 | 673 | 6752 | 9% |
| Regular day attenders | 6577 | 521 | 488 | 553 | 540 | 576 | 642 | 654 | 559 | 624 | 570 | 526 | 558 | 544 | 5793 | 5% |
| Total elective admissions | 54655 | 4844 | 4642 | 5275 | 4174 | 4007 | 4739 | 4847 | 3953 | 4896 | 4796 | 4378 | 4269 | 4658 | 44717 | 0% |
| % change on previous year | | 6% | 15% | 18% | 1% | -10% | 5% | 3% | 6% | 5% | 1% | -4% | -2% | -4% | | |

# Appendix - Activity (HWP)

| | 14/15 | Jan-15 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-16 | YTD | YTD % change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GP and general dental practitioner referrals to all outpatients** | | | | | | | | | | | | | | | | |
| NHS Slough | 34157 | 2913 | 2818 | 3188 | 2997 | 3005 | 3211 | 3071 | 2831 | 3301 | 3036 | 2926 | 2989 | 3135 | 30502 | 8% |
| NHS Windsor, Ascot & Maidenhead | 29710 | 2541 | 2490 | 2743 | 2470 | 2603 | 2621 | 2544 | 2212 | 2607 | 2417 | 2534 | 2330 | 2457 | 24795 | 1% |
| NHS Chiltern | 11957 | 1075 | 967 | 1225 | 1076 | 1091 | 1198 | 1104 | 1038 | 1174 | 1122 | 1126 | 1074 | 1146 | 11149 | 14% |
| NHS Bracknell & Ascot | 10715 | 887 | 806 | 1017 | 828 | 873 | 873 | 866 | 769 | 821 | 828 | 841 | 744 | 832 | 8275 | -7% |
| Other | 3202 | 232 | 249 | 300 | 231 | 257 | 292 | 260 | 219 | 267 | 249 | 247 | 258 | 220 | 2500 | -6% |
| Total | 89741 | 7648 | 7330 | 8473 | 7602 | 7829 | 8195 | 7845 | 7069 | 8170 | 7652 | 7674 | 7395 | 7790 | 77221 | 4% |
| % change on previous year | | -4% | 5% | 14% | 10% | 12% | 9% | 5% | 6% | 5% | -6% | 0% | 4% | 2% | | |
| **Outpatient attendances** | | | | | | | | | | | | | | | | |
| New attendances | 114355 | 9492 | 9024 | 9924 | 9275 | 9034 | 10428 | 10157 | 8539 | 10083 | 9850 | 9839 | 8943 | 9226 | 95374 | 0% |
| Follow-up attendances | 266930 | 22602 | 21535 | 24017 | 22522 | 21982 | 24574 | 23320 | 19840 | 23255 | 23237 | 23830 | 21870 | 22062 | 226492 | 2% |
| Total OP attendances | 381285 | 32094 | 30559 | 33941 | 31797 | 31016 | 35002 | 33477 | 28379 | 33338 | 33087 | 33669 | 30813 | 31288 | 321866 | 2% |
| % change on previous year | | 0% | 7% | 22% | 2% | -1% | 9% | 0% | 0% | 1% | -3% | 8% | 3% | -3% | | |
| **A&E attendances** | | | | | | | | | | | | | | | | |
| A&E attendances (total) | 111241 | 8930 | 8391 | 10100 | 9469 | 10083 | 9829 | 9919 | 9525 | 9598 | 9679 | 9757 | 9859 | 10240 | 97958 | 6% |
| % change on previous year | | -7% | -7% | -7% | 10% | 8% | 3% | 2% | 7% | 3% | 4% | 5% | 1% | 15% | | |
| **Non-elective admissions** | | | | | | | | | | | | | | | | |
| Non-elective admissions (total) | 40052 | 3754 | 3466 | 4056 | 3686 | 3783 | 3663 | 3768 | 3798 | 3914 | 4092 | 4018 | 4294 | 4272 | 39288 | 1% |
| % change on previous year | | 5% | 5% | 11% | 1% | 0% | -4% | -7% | 0% | -3% | -1% | 3% | 6% | 14% | | |
| **Elective admissions** | | | | | | | | | | | | | | | | |
| Daycase | 24156 | 1862 | 1869 | 2153 | 1983 | 2154 | 2215 | 2307 | 2025 | 2150 | 2249 | 2171 | 2022 | 2019 | 21295 | 6% |
| Overnight | 7453 | 593 | 612 | 758 | 605 | 616 | 707 | 664 | 590 | 656 | 633 | 614 | 574 | 566 | 6225 | 2% |
| Regular day attenders | 8861 | 819 | 793 | 923 | 745 | 688 | 785 | 831 | 708 | 811 | 749 | 708 | 647 | 760 | 7432 | 4% |
| Total elective admissions | 40470 | 3274 | 3274 | 3834 | 3333 | 3458 | 3707 | 3802 | 3323 | 3617 | 3631 | 3493 | 3243 | 3345 | 34952 | 5% |
| % change on previous year | | -4% | 2% | 13% | 0% | 0% | 15% | 7% | 9% | 12% | -3% | 7% | 0% | 2% | | |

# Appendix – Methodologies for calculating the measures

| Measure name | Numerator | Denominator | |
|---|---|---|---|
| **Length of stay** | ▪ Total number of bed days occupied<br>▪ Excludes private patients<br>▪ Excludes daycases<br>▪ Based on admission method, split between elective (from a waiting list) and non-elective admissions (includes emergencies and obstetrics) | ▪ Total number of discharges in the period | ▪ Expressed as a proportion<br>▪ Measure is consistent with that reported on HED (benchmarking service) |
| **Readmissions** | ▪ Emergency readmissions to any specialty following an elective or non-elective spell<br>▪ Readmission length of stay must be at least 1 day ie an overnight stay<br>▪ Readmission occurs within 30 days of previous discharge | ▪ Total number of discharges (completed spells) in the period prior to the last 30 days | ▪ Measure is consistent with that used by CQC |
| **Daycase %** | ▪ Total number of admitted spells where the intended management was daycase, they were admitted electively (off a waiting list) and their spell length of stay was 0 days | ▪ Total number of elective spells (admitted off a waiting list) | ▪ Expressed as a percentage |

# Appendix – Methodologies for calculating the measures

| Measure name | Numerator | Denominator | |
|---|---|---|---|
| **Outpatient new to follow-up ratio** | ▪ Number of follow-up outpatient attendances for all referrals and all appointment types (consultant and non-consultant led). Includes ward attenders and private patients | ▪ Number of new outpatient attendances | ▪ Expressed as a ratio where one new attendance results in “n” follow-up attendances<br>▪ Measure is consistent with that reported on HED (benchmarking service) |
| **Outpatient DNA rates** | ▪ Number of outpatient appointments where the patient did not attend. Includes all referrals and all appointment types (consultant and non-consultant led). Includes private patients | ▪ Number of outpatient attendances plus the number of appointments where the patient did not attend | ▪ Expressed as a percentage<br>▪ Measure is consistent with that reported on HED (benchmarking service) |

# Appendix – Methodologies for calculating the measures

| Measure name | Numerator | Denominator | |
|---|---|---|---|
| **Falls resulting in significant injury (rate per 1000 beddays)** | ▪ Falls recorded on Datix resulting in moderate or severe harm or death | ▪ Total number of occupied beddays (including daycases)<br>▪ Divided by 1000 | ▪ Expressed as a rate |

# Appendix - Glossary

| Term | Meaning |
|---|---|
| **CCG** | Clinical Commissioning Group |
| **CIP** | Cost Improvement Programme |
| **CoSRR** | Continuity of Services Risk Rating<br>*As from 1st October 2013 Monitor's new Risk Assessment Framework replaced the old Compliance Framework. Part of the change saw the Financial Risk Rating (FRR) being replace by the Continuity of Services Risk Rating. This measure is designed to describe the risk of a provider failing to carry on as a going concern. The scale is rated from 1 to 4 with 4 being 'No evident concerns' and 1 being 'Significant Risk'* |
| **CQUIN** | Commissioning for quality and innovation |
| **CRAB** | CRAB (Copeland's Risk Adjusted Barometer) is based on the POSSUM scoring system |
| **EBITDA** | Earnings before interest, tax, depreciation and amortization |
| **FHFT** | Frimley Health NHS Foundation Trust |
| **FPH** | Frimley Park Hospital (also referred to as the "South") |
| **HWP** | Heatherwood and Wexham Park Hospitals (also referred to as the "North") |
| **POSSUM** | Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity |
| **YTD** | Year to date |

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# BOARD

Frimley Health NHS
NHS Foundation Trust

| | |
|---|---|
| Report Title | NHS Staff Survey 2015 |
| Date of Meeting | 4th March 2016 |
| Agenda Number | |
| Report type | For information |
| Prepared by | Eleanor Shingleton-Smith, Deputy Director of OD |
| Executive Lead | Janet King, Director of HR and Corporate Services |
| Executive Summary | This paper highlights the results of the 2015 National Staff Survey and is the first set of combined results for Frimley Health. The Trust undertook a census survey in 2015 and had a 35% (2818) response rate. Acute trust benchmarking is based on a sample of the overall response (311) and was made publicly available on the NHS Survey website from 23rd February 2016.<br><br>The acute trust benchmarking for key factors for Frimley Health in 2015 is as follows:<br><br>• 12 scores in best 20% of acute trusts<br>• 9 above average<br>• 3 average<br>• 5 below average<br>• 4 in the worst 20%<br><br>These results are very positive for Frimley Health with improvements well on track or even exceeding our OD and People Strategy targets. The Trust can be proud of its best 20% scores which are in areas that are harder to achieve than others. However, it should be noted that the Trust is on the lower end of the 20% category for 5 of the 12 best 20% items. The overall recommendation must be to sustain and build on the engagement and leadership behaviours that are driving these improvements to ensure these scores become more established best 20% scores in the coming years.<br><br>The following is shown in the Background section:<br><br>• breakdown and scores by key factor (8 of the 33 key factors were new for 2015);<br>• Comparisons with 2014 legacy organisation benchmarking;<br>• Most and least positive staff perceptions (these help qualify the importance of the benchmarking and direct action planning);<br>• Local trust comparisons (Frimley Health is comparing favourably);<br>• Comparison of key factors by 3 main sites (sites are now remarkably similar with a few notable differences);<br>• Improving picture on overall engagement trends and values implementation.<br><br>Local results are not yet available but will be shared with managers for local action planning. Areas for corporate action are noted in the Issues and Options section. |

Background

**Key factor breakdown and scores**

Comfortable best 20% scores included:
- ☺ Overall staff engagement (3.88)
- ☺ Quality of appraisals (3.39)
- ☺ % experiencing bullying, harassment or abuse from other staff (20%)
- ☺ % reporting most recent experience of harassment, bullying or abuse (46%)
- ☺ % reporting good communication between senior management and staff (42%)
- ☺ Fairness and effectiveness of reporting procedures for errors, near misses, incidents (3.86)
- ☺ Effective use of patient/service user feedback (3.92)

Lower end of best 20% included:
- ☺ Staff recommendation of the trust as a place to work or receive treatment (3.92) – threshold was 3.90
- ☺ Staff satisfaction with quality of work and patient care they can deliver (4.03) – threshold was 4.02
- ☺ Recognition and value of staff by managers and the organisation (3.55) – threshold was 3.52
- ☺ Staff satisfaction with resourcing and support (3.42) – threshold was 3.40
- ☺ Staff confidence and security in reporting unsafe clinical practice (3.71) – threshold was 3.69

Above average scores included:
- ☺ Staff motivation at work (3.98)
- ☺ Staff satisfaction with level of responsibility and involvement (3.94)
- ☺ Effective team working (3.77)
- ☺ Support from immediate managers (3.72)
- ☺ % satisfied with opportunities for flexible working patterns (50%)
- ☺ % of staff suffering work-related stress (32%)
- ☺ % reporting most recent experience of violence (58%)
- ☺ % able to contribute towards improvements at work (72%)
- ☺ % reporting errors, near misses or incidents in last month (91%)

Average scores included:
- 😐 % feeling under pressure to attend work when feeling unwell (58%)
- 😐 % feeling organisation provides equal opportunities for career progression (88%)
- 😐 % witnessing potentially harmful errors, near misses or incidents in last month (30%)

Below average scores included:
- ☹ % agreeing their role makes a difference to patients/service users (90%)
- ☹ % working extra hours (75%)
- ☹ Organisational/management interest in and action on health and well-being (3.55)
- ☹ % experiencing physical violence from patients, relatives or the public (15%)
- ☹ % experiencing harassment, bullying or abuse from patients, relatives or the public (30%)

Lowest 20% included:
- ☹ % appraised (77%, acute average is 86%)
- ☹ Quality of non-mandatory training, learning or development (3.97, acute average is 4.03)
- ☹ % experiencing physical violence from staff (4%, acute average is 2%)
- ☹ % experiencing discrimination at work (14%, acute average is 10%)

**Comparisons with 2014 legacy organisation benchmarking**

| **Frimley Park in 2014** | **Heatherwood and Wexham Park in 2014** |
|---|---|
| • 17 best 20% | • 1 best 20% |
| • 6 above average | • 3 above average |
| • 5 at the average | • 8 average |
| • 1 below average | • 5 below average |
| • 0 worst 20% | • 12 worst 20% |

Although there were some significant changes in some of the questions asked in 2015, the 2014 benchmarking of our legacy organisations gives an indication of the scale of the improvements made in 2015. The 2015 benchmarking shows that Wexham Park and Heatherwood have made dramatic and positive improvements in their scores since 2014 whereas Frimley Park has reduced in some areas but still broadly maintained its scores.

**Best and worst % scores**

Benchmarking indicates how the Trust is doing in comparison with other acutes but it does not focus on actual scores. In some cases, this means that the Trust could be in the best 20% of all acute trusts, but the actual score could be poor. Similarly, the Trust could be in the worst 20% of acute trusts, but the actual score could still be a reasonably good one. Therefore, it is important to have an understanding of where the Trust has its best and worst % scores as these could provide important feedback for deciding where we need to act or not.

The top 10 best % scores for Frimley Health staff were:

- I am trusted to do my job 93%
- I always know what my work responsibilities are 92%
- I feel that my role makes a difference to patients/service users 91%
- My organisation encourages us to report errors, near misses or incidents 88%
- I am able to do my job to a standard I am personally pleased with 86%
- I am satisfied with the quality of care I give to patients/service users 85%
- I know who the senior managers are here 84%
- Care of patients/service users is my organisation's top priority 82%
- How satisfied are you with each of the following aspects of your job? The support I get from work colleagues 82%
- My organisation acts on concerns raised by patients/service users 79%

The 10 worst % scores for Frimley Health staff were:

- How satisfied are you with each of the following aspects of your job? My level of pay 34%
- Senior managers act on staff feedback 36%
- There are enough staff in this organisation for me to do my job properly 37%
- Senior managers here try to involve staff in important decisions 37%
- Communication between senior management and staff is effective 47%
- My organisation treats staff who are involved in an error, near miss or incident fairly 49%
- How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work 49%
- How satisfied are you with each of the following aspects of your job? The opportunities for flexible working 51%
- I am able to meet all the conflicting demands on my time at work 52%
- I am involved in deciding on changes introduced that affect my work area/team/department 53%

**Frimley Health Site differences**

Many of the key factors were similar for the three main hospital sites in 2015. For example, overall staff engagement was 3.91 for Frimley Park and 3.86 for Wexham Park and Heatherwood. The more significant differences were as follows:

- Wexham Park staff are less likely to recommend the trust as a place to work or have treatment than the other 2 sites (3.80 compared with 4.01 for Frimley Park and 4.00 for Heatherwood;
- Heatherwood has a higher staff satisfaction with quality of work and patient care they can deliver at 4.27 than the two acute sites (both at 4.03);
- Heatherwood is more satisfied with resourcing and support than the two acute sites at 3.62 (3.41 at Frimley Park and 3.40 at Wexham Park);
- Wexham Park has the best appraisal take-up at 85% whereas other 2 sites are lagging behind (Frimley Park at 75% and Heatherwood at 70%);

- Physical violence from patients is more likely at the acute sites (15% and 17% respectively at Frimley Park and Wexham Park and only 9% at Heatherwood);
- Wexham Park staff are more likely to report incidents of harassment, bullying and abuse than staff at Frimley Park (63% as opposed to 42% at Frimley Park).

**Comparison with local acute trusts**

| Benchmarking | FH | ASPH | RSCH | HH | RBH |
|---|---|---|---|---|---|
| Best 20% | 12 | 1 | 13 | 5 | 0 |
| Above Average | 9 | 3 | 11 | 13 | 3 |
| Average | 3 | 5 | 4 | 8 | 15 |
| Below Average | 5 | 8 | 2 | 4 | 9 |
| Worst 20% | 4 | 16 | 3 | 3 | 6 |

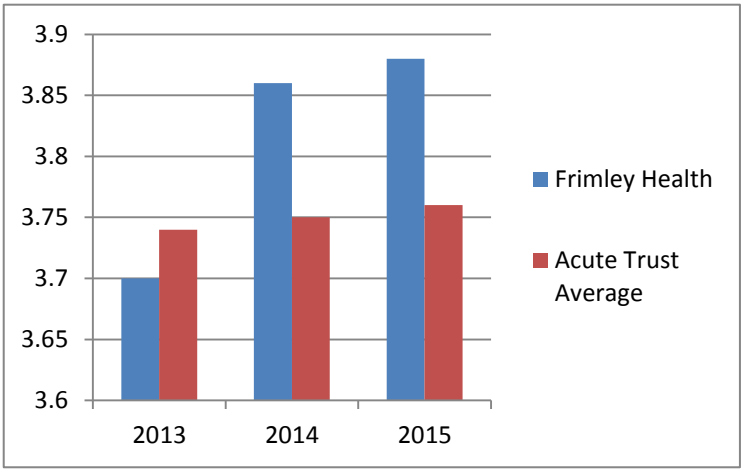
The above indicates that Frimley Health is comparing favourably with other local acute trusts.

**Overall staff engagement**

The NHS defines overall staff engagement as a combination of 9 items as follows, most of which have improved for Frimley Health since 2014:

| Engagement item | 2015 % agree | 2014 % agree | % Change |
|---|---|---|---|
| I look forward to going to work | 64 | 60 | +4 |
| I am enthusiastic about my job | 77 | 74 | +3 |
| Time passes quickly when I am working | 81 | 79 | +2 |
| There are frequent opportunities for me to show initiative in my role | 76 | 71 | +5 |
| I am able to make suggestions to improve the work of my team/department | 76 | 74 | +2 |
| I am able to make improvements happen in my area of work | 58 | 59 | -1 |
| Care of patients / service users is my organisation's top priority | 82 | 77 | +5 |
| I would recommend my organisation as a place to work | 67 | 65 | +2 |
| If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation | 78 | 73 | +5 |

If our legacy organisations had combined their overall engagement scores for 2013 and 2014, it would indicate an improving trend for Frimley Health for 2015.



**Values Implementation**

The wider census frequency data provides useful insight into the implementation of the Trust's values as follows:

- 99% (2730) of respondents were aware of the values
- 63% (1644) said their managers always or often demonstrated the values at work
- 67% (1748) said their colleagues always or often demonstrated the values at work

Whilst awareness of the values is very high, there is more to be done to ensure all managers are role-modelling the values.

Issues and Options

The Trust has a 3 year action plan for improving NHS Staff Survey targets. It has made good progress on achieving some of its targets for the 2015 NHS Staff Survey which were as follows:

| Item | 2014 Score | 2015 Target | 2015 Actual Score | % Change |
|---|---|---|---|---|
| Overall staff engagement | 3.86 | 3.90 | 3.88 | +0.02 |
| Communication between senior management and staff | 37% | 40% | 47% | +10% |
| Effective team working | 3.80 | 3.83 | 3.77 | -0.03 |
| % appraised | 80% | 80% | 77% | -3% |
| Support from immediate managers | 3.70 | 3.73 | 3.72 | +0.02 |
| % experiencing harassment from staff | 25% | 24% | 20% | -4% |
| % experiencing discrimination at work | 13% | 12% | 14% | +1% |
| % believing trust provides equal ops for career progression and promotion | 86% | 87% | 88% | +2% |
| Fairness and effectiveness of incident reporting | 3.60 | 3.65 | 3.86 | +0.26 |
| % agreeing would feel secure raising concerns about unsafe clinical practice | 68% | 70% | 71% | +1% |
| % of staff working extra hours | 72% | 71% | 75% | +3% |
| % suffering work-related stress | 33% | 31% | 32% | -1% |

It is recommended that we continue with year 2 of the Trust's 3 year corporate action plan to include the same areas included in year 1 but adding in the following:

- Improving perception organisational and managerial interest and action on health and well-being (this closely links with staff engagement)
- Improving perception of quality of non-mandatory learning, training or development
- Continuing to focus on communication and in particular how we ensure staff feel involved in and get feedback on decisions that affect them (4 of our worst % scores relate to these areas)

The overall and most important recommendation for leaders is however to sustain the positive leadership approaches that have driven up staff engagement over the last year

Recommendation

Board to note improvements in NHS Staff Survey 2015 and recommendations for action

Appendices

**BOARD**

Frimley Health NHS
NHS Foundation Trust

| | |
|---|---|
| Report Title | **Recruitment & Retention Update** |
| Meeting | Board of Directors in Public |
| Agenda Number | |
| Report type | For information and note |
| Prepared by | Tom White Assistant, Director of Resourcing, John Ireland, Deputy Director of HR |
| Executive Lead | Janet King, Director of HR and Corporate Services |
| Executive Summary | The attached provides an update on current vacancy and turnover risks across all clinical staff groups and the details actions that support the mitigation of these risks. These actions include:<br>• Developing our 'employee brand' to attract UK candidates<br>• Improving access to training and development and actively support the career progression of staff as part of a retention strategy<br>• Using international recruitment to fill current nursing vacancies<br>• Streaming the recruitment process and implementing a new recruitment system (TRAC) to improve both 'time to hire' and information reporting to managers.<br>• Enhancing current local induction for new starters<br>• Review the use of current recruitment pay incentive schemes |
| Background | This paper provides an update on the Recruitment and Retention action plan which was presented to the Board in August. |
| Issues | **Recruitment and Vacancy Update March 2016**<br><br>**1. Introduction**<br><br>In order to achieve our objective of delivering excellent clinical outcomes whilst maintaining a high quality patient experience, it is vital that we maximise the potential of our workforce. Key to this will be ensuring that we recruit and retain the right numbers of suitably trained staff, who share our values. This will be vital in terms of ensuring that we are able to reduce our reliance on temporary staffing and achieve the required efficiency savings. This paper outlines the key actions being taken forward.<br><br>**2. Qualified Nurses and Midwives**<br>**2.1 Performance Against Vacancy Trajectory**<br><br>Recruiting qualified nursing and midwifery staff continues to be extremely challenging. A recent review of nursing levels by NHS employers (Register Nurse Supply Findings, Jan 16) identified that 93% of Trusts reported experiencing registered nurse supply |

shortages, with a quarter of Trusts, reporting having over 150 vacancies.

Between April and January 2016 the Trust recruited 347 registered nurses and midwives (N&M) compared to 287 during the same period the previous year, which equates to a 21% increase in recruitment activity. During this period 340 N&M staff left the Trust, compared to 335 during the same period last year. The Trust currently has 300 N&M vacancies (65 at FP and 235 at HWP). Appendix A gives a breakdown of starters and leavers by hospital site.

In September 2015 a nursing vacancy trajectory (Appendix B) was produced which outlined a plan to reduce the nursing vacancy rate from 6.2% to 3.6% at FP and from 17.9% to 9.9% at HWP (against 95% establishment). Whilst at FP we are currently meeting the trajectory, at HWP we have seen an increase in overall vacancy rates to 20.6%, which is currently 2.1% over trajectory.
There are two key challenges for why we are currently failing to achieve the vacancy trajectory at HWP. Firstly the original trajectory planned for 57 international nurses starting before Jan 2016, however due to factors beyond our control we have only been able to recruit 21 of these nurses (see section 2 for further detail regarding International Recruitment). The second key factor has been turnover. We planned for a reduced turnover rate of 20% at WHP however turnover has remained at 25% which equates to 21 leavers per month (see section 3 for a detailed analysis on Turnover). In comparison, FP (which has a similar N&M establishment to HWP) has a turnover rate of 16% which equates to 15 leavers per month.

The trajectory in Appendix B has been revised for HWP and a new vacancy target of 15.4% has been set based on revised supply assumptions. In order for the Trust to achieve the vacancy trajectory target the Trust must employee 502 qualified nurses over the next 12 months. 411 of these positions will cover turnover whilst the remaining 95 will either fill new posts or support vacancy reduction. Current trends suggest that we will be able to recruit 288 nurses from the UK over the next 12 months leaving a potential gap of 218 which we will look to fill via international recruitment.

**2.2 International Recruitment**

In January last year the Trust undertook a recruitment campaign in the Philippines to recruit approximately 100 nurses and when we were there we made 120 job offers. In April 2015 the level of English competency was raised to level 7 IELTS . This has had a major impact on the campaign and unfortunately so far we have only been able to start seven nurses from this recruitment campaign, with three more with visa applications in train. There remains 55 nursing candidates who are still awaiting start dates however we have not been given any firm timeframes for when these nurses will start.

The government's decision to add nursing to the shortage occupation list in November has unfortunately not significantly improved our ability to clear these candidates to start. There remains significant delays in nurses being able to complete and pass IELT level 7 examinations (as there are few approved centres and the fail rate is approximately 70%). The recruitment market in the Philippines has changed significantly over the last 12 months and it now takes a significant amount of 'hand holding' of candidates in order to clear them to be able to work in the UK. This is resource intensive and it has become clear that the agency we have been using have not developed the expertise/resources in order to do this effectively and so we intend to change partners. Experiences from some other Trusts suggest that they have been more successful using another agencies.

In order to respond to the risks associated with recruitment in the Philippines, in October we launched a European Recruitment campaign with the agency, HCL. By offering a competitive benefits package (which was subject to candidates completing a minimal length of service with the Trust) we have been able to make 71 offers. 32 of these staff

have already started or have start dates and a further 18 are going through pre-employment checks anticipated to start in the next three months. The new NMC requirement (introduced on the 18th January) that all European nurses will need to achieve level 7 IELTs before registering with NMC will make recruiting in Europe more challenging going forward. We are exploring ways we can help support potential candidates pass the language examination.

## 3. UK Nurse Recruitment

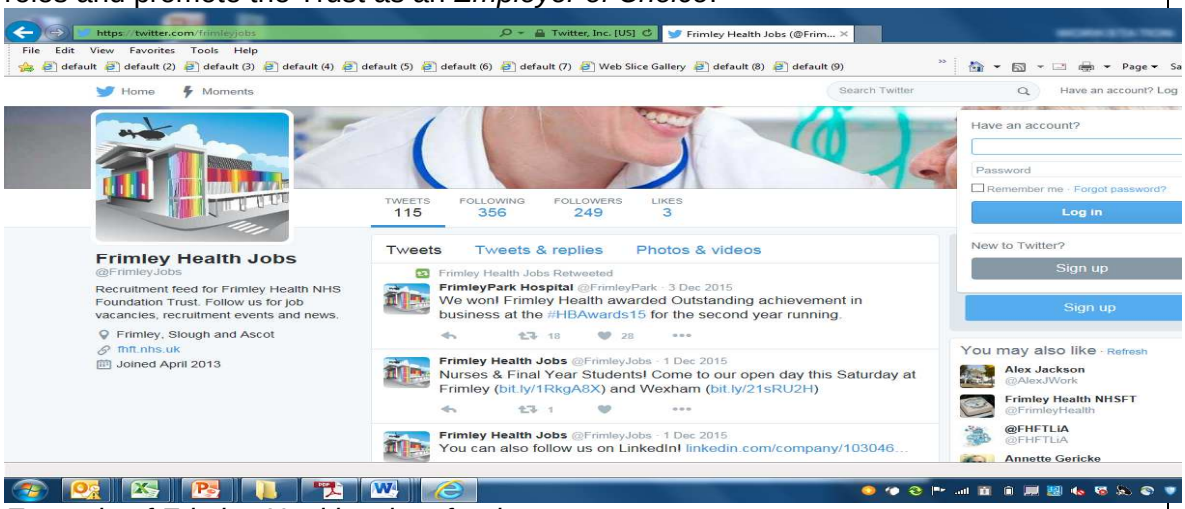
### 3.1 Golden Hello / Recruit a Friend

All nursing positions (in wards with a high vacancy) are now advertised with a £2k Golden Hello. In October we also introduced a £1,000 Recruit a Friend Scheme which has so far attracted over 20 applications for nursing positions. We will continue to promote the schemes for the foreseeable future and also consider other scheme such as subsidised Trust accommodation.

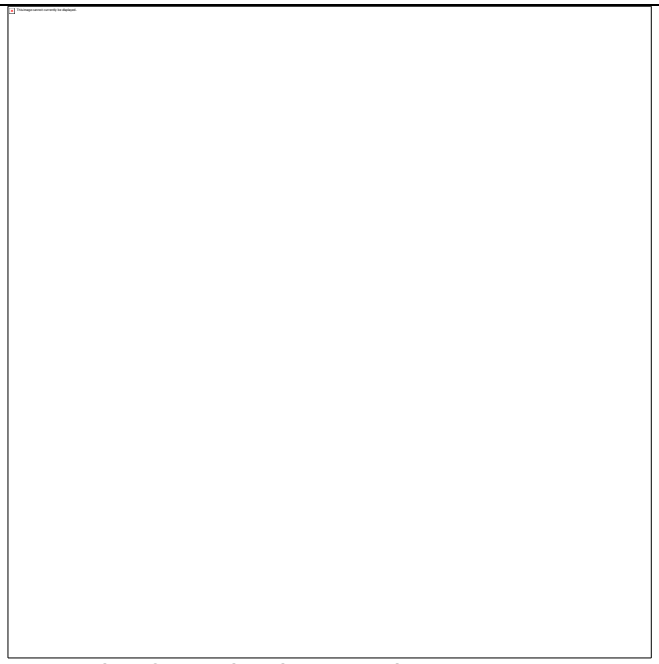
### 3.2 Online Advertising / Social Media

Since October we have increased our online advertising for nurse positions and have had running online adverts on both the RCN Bulletin and Nursing Standard websites. We have also worked with NHS jobs to improve the way perspective candidates can search and find nursing jobs on Frimley, Wexham and Heatherwood sites.

We now also have a strong presence on social media including Twitter (115 tweets), Facebook and Linktin and we are now in a position use these sites to advertise nursing roles and promote the Trust as an *Employer of Choice*.




*Example of Frimley Health twitter feed*



*Example of Facebook promotion*

### 3.3 Specialist UK Recruitment for Paediatrics, Neonates, Theatres and Critical Care)

We have worked with two recruitment specialists 'Sophie Bell' and 'Sterling Cross' who have been able to attract 18 applications to specialist nursing roles across all sites. So far we have made 8 offers of employment as a result of this work. In February we engaged with HCL permanent to help us source nurses from the UK to wards with high vacancy rates at Wexham Park.

### 3.4 Employer Branding

In order to increase the supply of UK applicants and to remain competitive with other employers, we initiated a piece of work to develop our employer brand. The recruitment and selection process (via online marketing, social media, advertising and recruit fairs etc.) offers us the opportunity to use the Frimley brand to not only attract potential candidates, but furthermore to build on our reputation both locally and nationally. Strong 'employer branding' is key and we need to develop messaging which makes use of the Frimley brand and maximises that for HWP.

Following a tendering exercise, WDAD Communications were selected as a preferred media partner to support us with this work. We have undertaken interviews and focus groups with various staff and other stakeholders to understand what makes us as an employer unique and attractive to perspective candidates. The research phase has now concluded and we are now at the design stage. This first create designs will be reviewed February with production of the first materials in March.

### 3.5 New Careers Website and Recruitment System

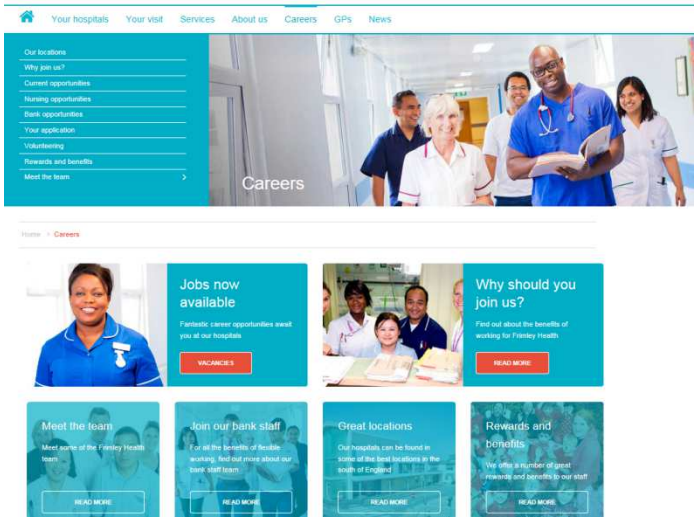
In December the Trust launched a new careers website. The new website is aimed at both attracting and informing perspective candidates to start or develop their nursing career at Frimley Health. New features include:

- Expression of interest forms
- Staff Testimonials
- Revised benefits information

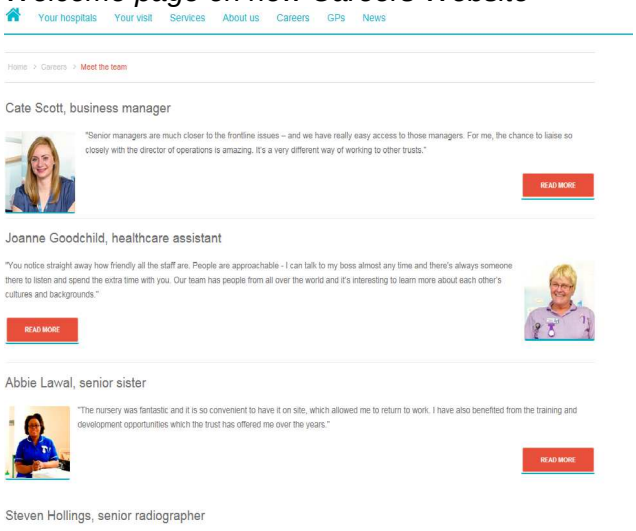
It is envisaged that we will continue to develop the website once the employer branding work is compete.

In January the Trust launched a new Recruitment system called TRAC. It is envisaged that the efficiencies created form this system will help us reduce the overall time to

recruit to help reduce vacancies.




*Welcome page on new Careers Website*




*Staff Testimonials on Careers Website*

## 4. Key Hard to Recruit Positions

### 4.1 Radiography

We have made significant progress in terms of reducing the number of vacancies radiographers and sonographers. Having refreshed previous the job adverts and completing focused online advertising we are currently in the process of processing 27 applications for Band 5 radiographer positions (7 Frimley and 20 Wexham). Interviews are being undertaken on a regular basis, including via Skype.

Below is a summary of current vacancies position across all sites

| Jan-16 | Wexham & Heatherwood | Frimley | Total |
|---|---|---|---|
| Post under offer | 7 | 5 | 12 |
| Posts unfilled | 9.97 | 8.6 | 18.57 |

Five sonographers have been recruited via Facebook/Linkedin/Twitter and an open day is also being arranged.

### 4.2 Occupational Therapists

Revised adverts are now in places which include Golden Hellos. Open days have been arranged throughout the year and we are exploring new alternatives to effectively advertising these roles.

| Jan-16 | Wexham & Heatherwood | Frimley | Total |
|---|---|---|---|
| Post under offer | 0 | 1 | 1 |
| Posts unfilled | 13 | 5 | 18 |

### 4.3 Operating Department Practitioners (ODPs)

| Jan-16 | Wexham & Heatherwood | Frimley | Total |
|---|---|---|---|
| Post under offer | 1 | 3 | 4 |
| Posts unfilled | 12 | 5 | 17 |

Open days are now in place and rolling adverts are being used to attract new candidates. A £2000 Golden Hello has been placed on all job roles. The department is considering options to train and develop staff internally rather than relying on external candidates.

### 4.4 Maternity

The maternity department have approximately 18.5 wte Band 5/6 midwives vacancies. We have recently initiated a new recruitment campaign and are currently advertising roles at Jobs.Midwives.co.uk . We are also initiating a social media campaign as well as organising recruitment open days.

### 4.5 Retention

- **Turnover Analysis:** We are currently designing a new web based exit interview process for all staff groups in order to provide more timely and detailed information regarding the causes of turnover. The current exit interview process in place is primarily paper based and we currently receive approximately 20% of forms returned. The aim of the new process will be to both improve the response rate and allow us the identity and monitor turnover hotspots.

  Turnover rates of Nursing and Midwifery staff is now monitored at ward level as part of the new Nursing and Midwifery Dashboard. This data currently suggests that whilst some turnover is as a result of 'relocation' factors at least 50% is the result of other voluntary factors such as; work life balance, career opportunities and flexible working. We envisage that by continuing to improve the line management support and guidance, as well as access to learning and development opportunities to staff we can significantly reduce this turnover. The actions below are helping us to achieve this.

- **Career Clinics:** The Career Clinic programme was launched in November 2016 and the programme is being run by the Trusts Clinical Education Team. This is a confidential support service to advise on career and professional development. The aim of these clinics is for staff to learn how they can gain access to learning and development opportunities as well discussing career progression. Dates for 2016 have now been confirmed and we will be exploring ways of how we can increase participation in the career Clinics.

| | |
|---|---|
| |  <br>• **Internal Transfer Window:** The aim of the transfer window will be to create a new process which encourages nursing staff to transfer to a new ward rather than seek external opportunities. A fast-track recruitment process will allow staff to transfer without going through a formal recruitment process. We are aiming to launch the transfer window in March and will review progress before considering options for other staff groups.<br><br>• **Staff Social & Recreational Activities:** We have secured fixed term funding via the transformation fund for a new post which will support the development of staff and social activities across the Trust. The role will be responsible for:<br><br>o Organising and maintaining a yearly social calendar this includes social and recreational events which represent staff across all staff groups and social demographics.<br>o Identifying ways to clearly communicate staff benefits to the staff.<br>o To work with the communications department to successfully promote and champion positive staff stories to local and national press.<br>o Work with Trust management teams to identify ways of supporting the local induction of new staff.<br>o Engage with staff living in Trust accommodation across all sites and identify and support strategies for improving the experience of staff.<br>o Work with the Health and Wellbeing group to organise and promote spots activities and events.<br><br>The aim will be to develop a programme which supports both the successful induction of new staff as well as engaging with existing staff to reduce turnover and improve retention. |
| Recommendation | The Board should note the actions the Trust is taking to reduce vacancy rates across staff groups. |
| Appendices | Appendix A: Nursing and Midwifery Starters and Leavers<br>Appendix B: Nursing and Midwifery Vacancy Trajectory |

**Appendix A:** Nursing and Midwifery Starters and Leavers

| Frimley Health Total | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014/15 N&M Starters | 17 | 18 | 23 | 11 | 13 | 54 | 53 | 49 | 8 | 41 | 287 |
| 2015/16 N&M Starters | 32 | 27 | 23 | 15 | 25 | 63 | 69 | 41 | 9 | 43 | 347 |
| 2014/15 N&M Leavers | 43 | 31 | 43 | 47 | 34 | 34 | 38 | 28 | 23 | 14 | 335 |
| 2015/16 N&M Leavers | 36 | 31 | 26 | 37 | 38 | 42 | 32 | 33 | 30 | 35 | 340 |

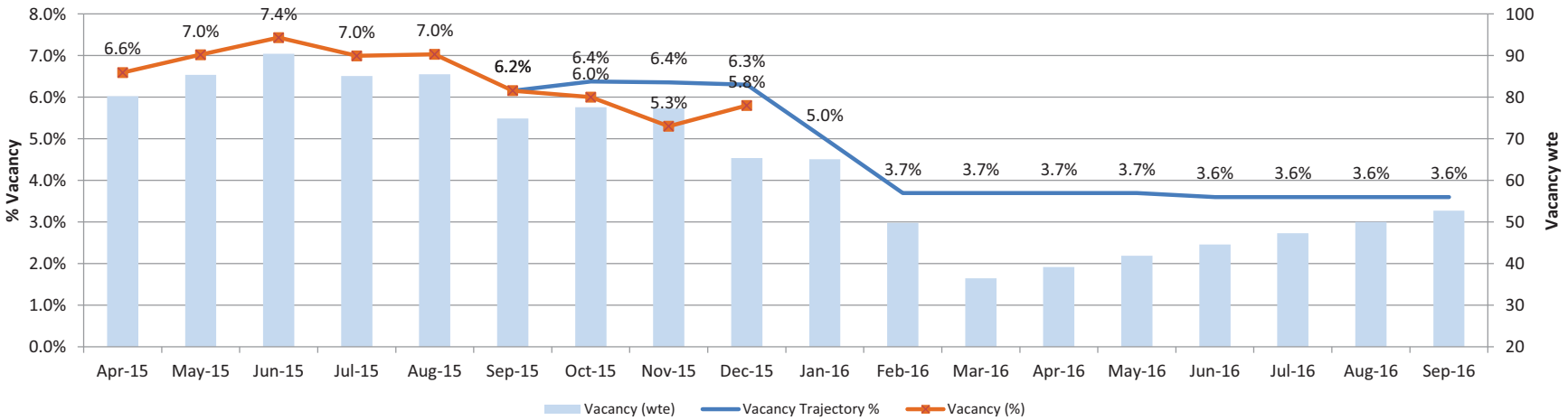
| Frimley Park | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 N&M Starters | 8 | 2 | 14 | 0 | 9 | 37 | 24 | 18 | 7 | 19 | 138 |
| 2015 N&M Starters | 19 | 17 | 13 | 9 | 17 | 50 | 36 | 21 | 8 | 19 | 209 |
| 2014 N&M Leavers | 12 | 14 | 18 | 23 | 11 | 19 | 17 | 16 | 8 | 5 | 143 |
| 2015 N&M Leavers | 11 | 12 | 12 | 17 | 13 | 20 | 10 | 12 | 9 | 16 | 132 |

| Heatherwood and Wexham Park | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 N&M Starters | 9 | 16 | 9 | 11 | 4 | 17 | 29 | 31 | 1 | 22 | 149 |
| 2015 N&M Starters | 13 | 10 | 10 | 6 | 8 | 13 | 33 | 20 | 1 | 24 | 138 |
| 2014 N&M Leavers | 31 | 17 | 25 | 24 | 23 | 15 | 21 | 12 | 15 | 10 | 193 |
| 2015 N&M Leavers | 25 | 19 | 14 | 20 | 25 | 22 | 22 | 21 | 21 | 19 | 208 |

| Frimley Park Vacancy Trajectory | *N&M Band 5 (+no pin), 6 & 7* | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | | | | | | | | | Planned | | | | | | | | |
| **Projected Vacancy Table** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
| 95% Establishment (wte) | 1217 | 1217 | 1217 | 1217 | 1217 | 1217 | 1217 | 1217 | 1132 | *1132* | *1132* | *1132* | *1132* | *1132* | *1132* | *1132* | *1132* | *1132* |
| Actual (wte) | 1136 | 1131.1 | 1126.1 | 1131 | 1131 | 1142 | 1139 | 1139 | 1067 | *1067* | *1082* | *1095* | *1093* | *1090* | *1087* | *1085* | *1082* | *1079* |
| Vacancy (wte) | 80 | 85 | 90 | 85 | 86 | 75 | 78 | 77 | 65 | 65 | 50 | 37 | 39 | 42 | 45 | 47 | 50 | 53 |
| Vacancy (%) | 6.6% | 7.0% | 7.4% | 7.0% | 7.0% | 6.2% | 6.0% | 5.3% | 5.8% | | | | | | | | | |
| **Vacancy Trajectory %** | | | | | | 6.2% | 6.4% | 6.4% | 6.3% | *5.0%* | *3.7%* | *3.7%* | *3.7%* | *3.7%* | *3.6%* | *3.6%* | *3.6%* | *3.6%* |
| | | | | | | | | | | | | | | | | | | |
| **Future Panned Recruitment Activity** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
| **UK (including Recruitment Days)** | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 |
| **UK Recruitment Agency / Headhunter** | | | | | | | | | | | | | | | | | | |
| **Student Intake** | | | | | | *13* | | | | | *15* | *15* | | | | | | |
| **Philippines Intake** | | | | | | | | | | | | *1* | | | | | | |
| **India Intake** | | | | | | | | | | | | | | | | | | |
| **European Recruitment Intake** | | | | | | | | 3 | 3 | 3 | 3 | | | | | | | |
| **Total Planned / Actual new Starters** | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 26.0 | 13.0 | 16.0 | 16.0 | 16.0 | 31.0 | 29.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 |
| | | | | | | | | | | | | | | | | | | |
| **Actual Starters (not internal)** | 7.0 | 11.0 | 10.0 | 6.0 | 8.0 | 13.0 | 26.0 | 18.0 | 7.0 | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Planned Turnover** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
| **Planned Monthly turnover (wte)** | *17.2* | *16.7* | *16.3* | *15.7* | *15.2* | *14.6* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* | *15.7* |
| **12 month turnover %** | 18.0% | 17.5% | 16.9% | 16.4% | 15.8% | 15.3% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% | 16.4% |
| | | | | | | | | | | | | | | | | | | |
| **Actaul Monthly Leavers (wte)** | 10.0 | 12.0 | 12.0 | 17.0 | 11.0 | 17.0 | 10.0 | 12.0 | 9.0 | | | | | | | | | |

**Frimley Park Nursing and Midwifery (Qualified) Vacancy Trajectory wte 2015/16** (95% Establishment)

*Source: ESR*



**Heatherwood and Wexham Park** *N&M Band 5 (+no pin), 6 & 7*

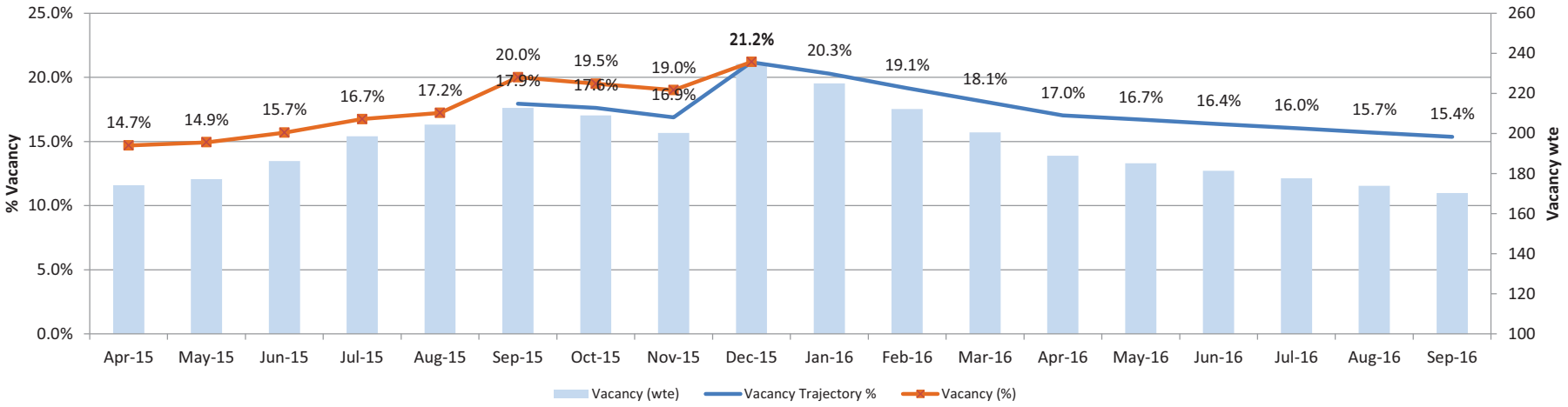
| | Actual | | | | | | | | | Planned | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Projected Vacancy Table** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
| 95% Establishment (wte) | 1186 | 1186 | 1186 | 1186 | 1186 | 1186 | 1186 | 1186 | 1109 | *1109* | *1109* | *1109* | *1109* | *1109* | *1109* | *1109* | *1109* | *1109* |
| Actual (wte) | 1012 | 1009 | 1000 | 988 | 982 | 973 | 977 | 986 | 874 | *884* | *896* | *908* | *920* | *923* | *927* | *931* | *935* | *938* |
| Vacancy (wte) | 174 | 177 | 186 | 199 | 204 | 213 | 209 | 200 | 235 | *225* | *212* | *201* | *189* | *185* | *181* | *178* | *174* | *170* |
| Vacancy (%) | 14.7% | 14.9% | 15.7% | 16.7% | 17.2% | 20.0% | 19.5% | 19.0% | 21.2% | | | | | | | | | |
| **Vacancy Trajectory %** | | | | | | 17.9% | 17.6% | 16.9% | 21.2% | *20.3%* | *19.1%* | *18.1%* | *17.0%* | *16.7%* | *16.4%* | *16.0%* | *15.7%* | *15.4%* |

| **Future Recruitment Activity** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **UK (including Recruitment Days)** | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 |
| **UK Recruitment Agency / Headhunter** | | | | | | | | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| **Student Intake** | | | | | | 6 | 13 | 6 | 1 | 4 | 3 | | | | | | | |
| **Philippines Intake** | | | | | | | | 3 | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| **European Recruitment Intake** | | | | | | | | 7 | 0 | 13 | 13 | 15 | 15 | 7 | 7 | 7 | 7 | 7 |
| **Total Planned / Actual new Starters** | 11.0 | 11.0 | 11.0 | 11.0 | 11.0 | 17.0 | 24.0 | 29.0 | 14.0 | 30.0 | 33.0 | 32.0 | 32.0 | 24.0 | 24.0 | 24.0 | 24.0 | 24.0 |
| **Actual Starters (not internal)** | 7.0 | 11.0 | 10 | *6* | *8* | 13.0 | 31.0 | 19.0 | 1.0 | | | | | | | | | |

| **Planned Turnover** | **Apr-15** | **May-15** | **Jun-15** | **Jul-15** | **Aug-15** | **Sep-15** | **Oct-15** | **Nov-15** | **Dec-15** | **Jan-16** | **Feb-16** | **Mar-16** | **Apr-16** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Sep-16** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Monthly turnover (wte) | *21.1* | *21.0* | *20.8* | *20.6* | *20.5* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* | *20.3* |
| 12 month turnover % | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% | 25.0% |
| **Actaul Monthly turnover (wte)** | 25.0 | 22.0 | 15.0 | 22.0 | 23.0 | 20.0 | 22.0 | 21.0 | 21.0 | | | | | | | | | |

**HWP Nursing and Midwifery (Qualified) Vacancy Trajectory wte 2015/16** (95% Establishment)

*Source: ESR*



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Frimley Health NHS
NHS Foundation Trust

# BOARD REPORT

**March 2016**

**Title:** Nurse & Midwifery Staffing: March 2016

**Purpose:**
This paper provides the Trust Board with an overview of midwifery and nurse staffing levels as required every six months by NHS England *Hard Trusts* report across Frimley Health NHS Foundation Trust.
There is significant national focus on nursing and midwifery staffing levels and this paper provides the Board with an overview of nursing and midwifery staffing levels in relation to:

- The nursing and midwifery staffing framework
- The budgeted staff to patient ratio
- Patient Acuity and Dependency
- Current vacancies – identifying any areas of concern
- Future actions

This paper should be read in conjunction with the Recruitment & Retention update provided by the Director of Human Resources to this Trust Board

**Recommendation:**

The Board is asked to note the current position and discuss the key areas of focus for the next six months.

| **Prepared by:** | **Presented by:** |
|---|---|
| **Nicola Ranger: Director of Nursing**<br>**Heads of Nursing**<br>**Sally Brittain: Deputy Director of Nursing H&WP** | Nicola Ranger, Director of Nursing and Quality |

## 1. Introduction

The Trust Board are aware that nationally there has been a great deal of focus on nurse ward staffing levels and the profound impact this has on the quality and safety of patient care. This set against a backdrop of a challenging financial environment so it is essential that we develop a stable and talented workforce that is managed effectively and efficiently on all sites.

Every six months, as required by the NHS England *Hard Trusts* report, this paper is presented to the Board to provide an overview of midwifery and nurse staffing levels and can be benchmarked against the previous paper presented to the Trust Board in August 2015.

## 2. Nursing & Midwifery Framework

### a) Nursing

The Hospital Executive Board previously approved the following principles, as recommended by NICE, which remain unchanged from the previous staffing paper and are enshrined within all considerations and decisions related to nurse staffing.

- A minimum of 2 trained nurses on duty in all ward areas, twenty four hours a day, seven days a week.
- The ratio of trained nursing staff to beds to be a maximum of 1:8 during the day and 1:10 at night.
- The ratio is translated into the planned number of nurses on duty on both day and night shifts at ward level which is then submitted monthly to the DH Unify System. Compliance against the number of nurses is set at ward level within the Trust at 95% at night and 85% as during the day when there is more support available from Senior Sisters, Matrons and Heads of Nursing. Detail available at Appendix 1 & 2.
- There are national discussions about various staffing models which can be utilised i.e. contact hours however 1:8/1:10 ratio remains the key model that is evidence based. (Griffiths, P. 2015)

The process for preparing nurse off duty and managing safe staffing compliance remains unchanged from that stipulated within previous Trust Board papers.

As an aid memoire safe staffing compliance in real-time is undertaken on all sites which review ward staffing levels prospectively daily across all shift patterns at every bed meeting with the specific Matron and Head of Nursing. Staff maybe reallocated, temporary staff requested or the Matron or Head of Nursing work clinically in order to maintain patient safety over the next 24-48 hours. There is a robust process in place for the escalation of staffing concerns up to, where necessary, the Director of Operations and the Director of Nursing. Out of hours any staffing concerns are reviewed and actions taken by the Senior Duty Nurse and/or manager on call.

## b) Acuity & Dependency

Throughout the Trust some wards will have a higher nursing staff to bed ratio in recognition of the increased acuity and dependency of the patients on the ward. An acuity and dependency tool is formally undertaken three times per year throughout the organisation in order to triangulate agreed staffing establishments, the required ratios and the clinical need of the Trust patients. October 2015, February 2015 and June 2015 results are available for discussion benchmarked against previous data.

## c) Midwifery

Midwifery ratios have been determined on the basis of the midwifery staff required to deliver a safe and high quality maternity service, as set out most recently in *Maternity Matters* (DH, & Safer Childbirth) but also incorporating all existing policy and guidance. As previously detailed the recommended ratios are based on staffing requirements to deliver NICE guidance and a minimum of one to one care in labour for all women, plus increased midwife time for women and babies with greater needs because of their medical or social circumstances along with providing a community midwifery service. The Midwifery ratio is established on 3 points:-

- Number of births in totality
- 1:1 ratio for Intrapartum care
- Community midwifery 1:100

Senior Midwives review staffing daily and based on activity midwives will be deployed according to clinical need. Both maternity units continue with a ratio of 1:30 and a 90/10 skill mix of registered midwives to midwifery support workers (band 3/4).

There are currently 18.22 wte vacancies on the Wexham Park site which will rise to 20.22 wte by 31st March. The unit is waiting 3.4 wte new starters who were interviewed in November 2015 but not yet in post. On the Wexham Park site there is an increased difficulty in recruiting that sites own students and attracting newly qualified Band 5 midwives. The last two rounds of recruitment have resulted in 12 posts being offered to the site specific students however these offers have not resulted in actual recruitment. When questioned the students reported their choice is based purely on finance, surrounding trusts' (Watford and Hillingdon) are offering a band 6 to newly qualified midwives and with the higher London weighting, this is equating to between 7-9k difference to the offer of a band 5 at Wexham. This issue may require further discussion and consideration by the Head of Midwifery and Director of Nursing.

The Frimley Park site currently has a vacancy of 2.29 wte permanent posts and 2.5 wte fixed term. At the last recruitment, it was noted that the calibre of candidates was not as high as previously experienced.

Frimley Park have never utilised agency midwives.

Since April 2015 agency staff have been utilised on two occasions on the Wexham Park site. However this is becoming difficult to maintain due to the vacancy factor on the unit, and the reluctance of our own staff to work with NHSP, therefore a threshold for considering the utilisation of agency staff has been agreed with the Head of Midwifery and Director of Nursing.

## 3. Challenges to Maintaining Safe Staffing Levels and Resultant Actions

### a) Current Vacancies

There remains a significant challenge to maintaining nurse staff ratio's, particularly in the Medical Directorate on the Wexham Park site, due to the high proportion of permanent vacancies. Detailed breakdown of current vacancies is at Appendix 3.

| Site | Directorate | Total Vacancies (RN) | Total Vacancies (HCA) | Total Vacancies |
|---|---|---|---|---|
| Wexham Park | Medicine/ED | 143.04 | 18 | 161.04 |
| Wexham Park | Surgery/ITU | 9.4 | 1 | 10.4 |
| Wexham Park | T/O | 14.88 | 5 | 19.88 |
| Paediatrics | | 23.82 | 5.58 | 29.4 |
| Private Patients | | 9.2 | 4.5 | 13.7 |
| Frimley Park | Medicine/ED | 44 | 19.42 | 63.42 |
| Frimley Park | Surgery/ITU | 12.78 | 8.69 | 21.47 |
| Heatherwood | Surgery | 0 | 0 | 0 |
| Total | | 257.12 | 62.19 | 319.31 |

**Action** Staffing has been risk assessed prospectively given the above information and remains on the risk register. There is a daily focus and process to ensure the wards are safely staffed with bank and agency staff utilised in order to maintain current ratios. The key focus of the directorate and senior nursing team is to ensure that vacancies and staffing does not adversely impact patient safety and experience. This is achieved by Heads of Nursing and Matrons monitoring ward dashboards closely and presenting them to the Directorate Governance Meetings and the Director and Deputy Director of Nursing on a monthly basis as a minimum.

Areas with enhanced focus currently at Wexham Park Hospital are

a. Ward 1 (vacancy rate)
b. Ward 6 (vacancy rate and clinical concerns related to deteriorating patient and fall resulting in death- **Action Plan in place and being monitored**)
c. Ward 3 (vacancy rate)
d. Ward 9 (vacancy rate)
e. Ward 10 (4 RN on Mat Leave and increased turnover)
f. AMU ( high vacancy rate impacting skill mix- **Action shortlisted Band 4 role to support patient care and experience- not impacting skill mix**)

And Frimley Park Hospital

g. F9 (vacancy rate and **clinical concern around infection control**)
h. Bourne Ward at Farnham Hospital (9 RN & 5 HCA's seconded from the Medical Directorate)
i. Approximately 25 staff on secondment ranging from band 2 to band 8a, this potentially leaves a temporary vacancy which is not always apparent.
j. G5 (vacancy rate and ward review undertaken as a result of falls resulting in #NOF -**Action Plan in place**)

All areas where staffing or other concerns are noted are subject to close monitoring.

**Paediatric staffing is of concern on both sites.**

Multiple initiatives are in progress to improve recruitment and aid retention including engaging in the Trust wide overseas recruitment as well as national rolling adverts for all vacant posts.
Establishment skill mix has been amended increasing the band 6's and reducing the band 5's with the appropriate wte to ensure there is no financial impact with the aim of optimising candidates applying. Rotational/part-time and shorter shift posts are available to aid recruitment. Lines of work have been agreed with agency workers to provide continuity and quality of agency staff at reduced rates and band 4 competencies are under review to up skill and provide additional support the RSCN/RN.

**There is no evidence of compromise to patient safety or experience within Paediatrics.**

## b) Recruitment & Retention

Additional detail, performance and actions in relation to recruitment and retention can be found in the additional Human Resources paper presented to this Board

Of note for the Board, the most critical area in relation to recruitment is AMU at Wexham Park followed by Ward 6 and Ward 9. The following actions have therefore been agreed.

**Action**
Short Term Urgent Action:

- European Recruitment of 15 nurses to Medicine specifically
- Revise all Medicine adverts to include 'Golden Hello' and offer of 3 months subsidised Trust accommodation
- UK headhunting for Band 5 posts.
- Specific online advertising campaign for AMU posts.
- Clarification of AMU budget and vacancy position.
- Organise/advertise specific open day for Medicine Roles.
- Email confirmation to HoN/ADs regarding current status of international recruitment
- Confirm with *teams that the for Band 5 nursing positions we do not need financial approval to advertise as these should be rolling adverts.*

Medium Term Actions

- Revise current N&M Dashboard (to be send to HoN and HRBPs) to include TRAC information regarding current recruitment activity
- Include on dashboard current status of international recruitment (specific information where staff are going (hospital site)

The Trust Board is also asked to note that there has been a 40 % reduction in CPD for Health Education Thames Valley. This has the potential to impact retention and quality for the Trust.

**Action**
Paper to be presented to Top Team for consideration of providing uplift for education to support the reduction imposed.

**Innovation**
The Trust are recruiting ten band 4 associate practitioners for AMU on the 11th March, with further role out of band 4 roles under "nurse associate or "associate practitioner" title pending the current review. There are currently 35 applicants who have been shortlisted for interview with a plan to place 10 on AMU and 10 within ED. In both these areas this can be done without adversely affecting the trained nurse to staff ratio.

## Student Nurses

Student recruitment across Frimley Health remains at 90% for the last 2 cohorts, student experience remains positive and feedback on their 3 year in house training including simulation remains excellent. A robust clinical education team is now established in post on the wexham site supporting the students in practice and education setting.
The trust provides monthly local faculty groups based on the medical model to ensure a trainee voice that encompasses any concerns and alterations required to the programme.

The Trust Board is asked to note the loss of the bursary currently awarded to student nurses next year

**Action:** To monitor and maintain student retention. To consider various support mechanisms the Trust could deploy to support nurses in training. To improve the quality of nurse training and reduce the travelling burden for UWL students by offering placements across all three Trust sites.

## Preceptorship

The Frimley Park site Preceptorship programme has now been adopted across Frimley Health. This mandated programme is provided to all newly qualified nurses to the trust. It commenced at the Wexham site in September and initial feedback is good. A preceptorship lead is now in post on each site.
The trust provides monthly local faculty groups based on the medical model to ensure a trainee voice that encompasses any concerns and alterations required to the programme

**Action:** To monitor the impact of the preceptorship programme with recruitment and retention across Frimley Health.

### c) Sustained Financial Balance

One of the goals of the newly formed Trust is to ensure financial stability and as part of that aim is to significantly reduce and eliminate the reliance on agency nurses. Difficult to recruit to areas have been granted an enhanced bank rate with the aim of encouraging staff to book bank shifts rather than do agency elsewhere thus reducing the financial burden to those wards and areas and enhancing quality.

**Action** All Senior Sisters and Matrons are aware of budgetary controls and discuss them on a very regular and frequent basis with the Head of Nursing, Management Accountant and Associate Director. In addition budgetary control and quality and safety form part of every 1:1 discussion with Senior Sisters and Matrons with significant challenge and robust decision making as a result. There are standard operating procedures and policies to ensure that staffing concerns are escalated and therefore assessed at a senior level, this ensures that while safety will always be paramount maintaining financial balance is also considered when making decisions about staffing.

### d) Specials Training

Specials Study Days ran from August – December 2015 with a total of 39 registered and unregistered staff attending. Agenda available at Appendix 4

The subsequent feedback has been positive, staff are feeling more confident after receiving this 1-2-1 supervision training. In particular the session which includes Dementia, Delirium and Psychosis draws on the acute deterioration of the patient and this has given the staff a more comprehensive understanding of the physical and mental processes.

The managing difficult behaviour session talks through guidelines which are then reinforced in the afternoons scenarios. Also included in the afternoon session Emotional Resilience is covered which many staff have not experienced and feel that they have benefited not only professionally but personally. The alcohol withdrawal session is received very well and gives an overall insight for staff to use in practice. Following the study day staff are asked to complete a workbook and staff meet with the Dementia Lead approximately 6 weeks later which staff feel is beneficial to them.

**Action** It is the ambition of the Trust to recruit and develop a skilled team of HCA's who regularly provide close supervision and therefore enhance quality and patient experience while reducing cost. The scheme above will be rolled out Trust wide following the evaluation as above. In addition make contact with other Carter Trusts to establish if they can share any innovation with Frimley Health.

## Priorities for the next 6 months

- With the Staffing Matron now in post establish daily tracking of staffing compliance electronically to provide more robust overview of staffing in real time (currently undertaken in hard copy)
- Following completion of the upgrade to E-Roster review rota management to ensure it is available in a timely manner, equitable and provides appropriate skill mix.
- Consider a rolling rota in a variety of forms across the Trust in addition to offering alternatives such as annualised hours contracts or set days and hours.
- Once the bank E-Roster system is in place ensure access to all staff remotely in order that they can self book into bank shifts.
- Implement rotational programmes across the Trust for trained staff initially.

## Conclusion

As identified within this paper the Trust continues to experience a significant challenge when recruiting nursing and midwifery staff and while recruitment remains a major focus it has been acknowledged that retention of our staff should must be a high priority. To that end a staffing matron has been recruited to work alongside the Senior Sisters and Matrons, and with the senior nurses to promote innovation and consider new ideas to encourage staff not to leave the organisation such as accessing professional development, enhancing education options, the internal transfer window where staff can instead of leaving the Trust move within it in order to gain further experience, enhancing the career pathways within the Trust and introducing a Senior Sister position and ensuring the duty roster is equitable. In addition to these measures consideration is being given to the use of other roles such as the associate nurse and development of the band 4 role in order to support the ward function and release the nurses and midwives to provide direct clinical care.
The Trust has recently established individual Healthcare Assistant and Staff Nurse Forums to ensure that these staff have a voice within the Trust and the Deputy Directors of Nursing will be meeting quarterly with all new starters to actively listen to any concerns that maybe raised with a view to actioning changes that need to be made and encourage and enable retention

**Safe Staffing (Hard Truths) Unify Return**
Compliance measured in hours (includes '*Specials*').
Source: DoH Unify Site Level Report.

Percentage of actual hours against planned hours

| | Frimley Park | Wexham Park | Heatherwood |
|---|---|---|---|
| July 2015 | 91.4% | 97.4% | 91.9% |
| August 2015 | 91% | 93.8% | 97.9% |
| September 2015 | 92% | 95.3% | 93.1% |
| October 2015 | 93.7% | 95.4% | 96.5% |
| November 2015 | 95.6% | 92.2% | 97.7% |
| December 2015 | 90.1% | 90.3% | 97.4% |

Staffing Compliance by Ward by Month. Target 95% (Night) 85% (Day) Appendix 2

| Frimley Park Ward Name | Jul-15 | | Aug-15 | | Sep-15 | | Oct-15 | | Nov-15 | | Dec-15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate |
| Coronary Care Unit (CCU) | 89.7% | 98.8% | 90.0% | 97.2% | 97.9% | 99.2% | 98.8% | 100.0% | 100.4% | 99.2% | 100.0% | 100.0% |
| Cystic Fibrosis Unit (CFU) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| F1 Paediatric and Teenage Unit | 93.5% | 79.6% | 103.0% | 87.1% | 106.4% | 100.0% | 92.2% | 83.3% | 96.1% | 90.0% | 93.8% | 83.9% |
| F10 | 99.6% | 98.4% | 97.6% | 96.8% | 98.3% | 95.8% | 94.4% | 93.5% | 97.5% | 95.8% | 98.4% | 93.5% |
| F11 | 100.0% | 99.2% | 100.8% | 100.0% | 100.8% | 100.0% | 100.0% | 99.2% | 100.0% | 100.0% | 99.2% | 100.0% |
| F14 | 87.8% | 100.0% | 93.1% | 96.8% | 90.8% | 100.0% | 89.0% | 98.4% | 94.3% | 100.0% | 86.4% | 100.0% |
| F15 | 100.0% | 98.4% | 100.0% | 98.4% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| F2 | 94.8% | 100.0% | 92.3% | 100.0% | 90.0% | 100.0% | 93.5% | 100.0% | 94.0% | 101.7% | 87.1% | 100.0% |
| F3 | 80.9% | 90.8% | 74.2% | 90.8% | 69.7% | 91.0% | 76.8% | 88.9% | 76.1% | 91.9% | 74.2% | 90.3% |
| F4 | 94.9% | 98.4% | 94.0% | 100.0% | 92.9% | 98.9% | 88.8% | 100.0% | 94.0% | 100.0% | 93.0% | 100.0% |
| F5 | 88.8% | 100.0% | 94.1% | 100.0% | 93.7% | 98.9% | 90.2% | 100.0% | 93.6% | 100.6% | 94.1% | 96.7% |
| F6 | 102.0% | 109.0% | 76.3% | 92.6% | 89.5% | 112.3% | 91.2% | 114.9% | 94.1% | 115.2% | 80.7% | 92.6% |
| F7 | 74.1% | 97.8% | 80.9% | 105.6% | 79.8% | 101.1% | 79.2% | 100.0% | 84.2% | 100.6% | 82.5% | 101.1% |
| F8 | 90.1% | 98.9% | 93.7% | 100.0% | 95.2% | 101.1% | 93.8% | 98.9% | 94.8% | 102.3% | 95.4% | 99.4% |
| F9 | 80.4% | 99.5% | 80.7% | 100.0% | 78.9% | 100.0% | 84.9% | 100.0% | 82.6% | 100.0% | 86.8% | 100.0% |
| G1 | 95.2% | 101.6% | 96.8% | 100.0% | 96.7% | 100.0% | 97.3% | 100.0% | 98.3% | 100.0% | 98.9% | 132.3% |
| G2 | 91.8% | 83.9% | 88.5% | 80.6% | 90.7% | 83.3% | 90.3% | 83.1% | 94.8% | 77.5% | 94.6% | 85.5% |
| G3 | 95.6% | 83.9% | 90.3% | 105.6% | 93.1% | 82.5% | 93.7% | 83.1% | 101.7% | 90.0% | 98.4% | 91.1% |
| G5 Respiratory | 73.6% | 91.6% | 64.9% | 83.5% | 67.6% | 85.3% | 69.6% | 85.8% | 76.1% | 97.8% | 80.4% | 100.7% |
| G9 Cardiac Step Down | 86.6% | 92.6% | 90.3% | 93.1% | 85.3% | 85.7% | 87.9% | 88.5% | 94.2% | 102.2% | 95.2% | 103.2% |
| Acute Dependency Unit (ADU) | 98.0% | 99.2% | 98.8% | 96.0% | 98.8% | 98.3% | 97.6% | 96.0% | 97.5% | 100.0% | 96.4% | 96.0% |
| Intensive Care Unit | 89.8% | 86.8% | 87.9% | 88.1% | 91.8% | 90.7% | 100.2% | 97.7% | 94.0% | 92.3% | 95.2% | 95.2% |
| Maternity | 85.7% | 86.1% | | | | | | | | | | |
| Neonatal Unit (NNU) | 102.0% | 129.0% | 101.6% | 96.0% | 98.5% | 99.2% | 110.5% | 98.4% | 114.2% | 100.8% | 114.9% | 101.6% |
| Medical Assessment Unit/G4 (MAU/AMU) | 98.5% | 97.3% | 90.1% | 97.3% | 93.8% | 97.8% | 91.3% | 99.5% | 92.7% | 97.8% | 92.5% | 95.7% |
| Surgical Assessment Unit (SAU) | 92.7% | 101.6% | 94.1% | 100.0% | 93.6% | 100.0% | 94.8% | 98.4% | 100.0% | 99.1% | 94.4% | 96.7% |
| Short Stay Surgery (SSS) | 100.8% | 101.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 101.6% | 100.0% | 100.0% | 99.2% | 96.7% |
| Surgical Day Unit (SADU) | 82.8% | 87.1% | 78.3% | 84.7% | 82.2% | 85.3% | 97.6% | 78.1% | 108.6% | 86.2% | 106.5% | 82.7% |

Staffing Compliance by Ward by Month. Target 95% (Night) 85% (Day) Appendix 2

| Heatherwood & Wexham Park Ward Name | Jul-15 | | Aug-15 | | Sep-15 | | Oct-15 | | Nov-15 | | Dec-15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate | Day Nurse Fill Rate | Night Nurse Fill Rate |
| Ward 01 Orthopaedic (WP) | 98.2% | 98.7% | 94.2% | 100.0% | 87.2% | 98.1% | 94.4% | 100.6% | 89.8% | 100.7% | 90.8% | 99.4% |
| Ward 01 Surgical Short Stay Unit (Hwd) | 80.7% | 111.1% | 93.8% | 100.0% | 83.0% | 100.0% | 91.9% | 100.0% | 96.2% | 100.0% | 93.3% | 100.6% |
| Ward 02 General Medicine (WP) | 90.1% | 100.0% | 79.8% | 100.0% | 80.9% | 100.0% | 83.9% | 98.9% | 85.8% | 101.1% | 79.8% | 98.9% |
| Ward 03 General Medicine (WP) | 87.1% | 100.0% | 87.9% | 96.8% | 84.2% | 96.7% | 93.5% | 101.1% | 83.9% | 97.8% | 90.2% | 98.8% |
| Ward 04 General Medicine (WP) | 88.6% | 102.3% | 89.9% | 85.6% | 88.5% | 107.7% | 84.8% | 104.2% | 83.7% | 95.7% | 81.9% | 97.8% |
| Ward 04 Orthopaedic (Hwd) | 99.4% | 100.0% | 100.0% | 100.0% | 99.1% | 100.0% | 98.7% | 100.0% | 97.7% | 100.0% | 99.4% | 100.0% |
| Ward 05 Geriatric Medicine (WP) | 84.0% | 94.2% | 85.6% | 96.8% | 75.8% | 98.3% | 87.1% | 100.5% | 84.4% | 95.0% | 78.1% | 99.2% |
| Ward 06 General Medicine (WP) | 98.5% | 96.8% | 78.7% | 98.4% | 95.1% | 99.2% | 94.2% | 99.2% | 82.0% | 100.0% | 79.4% | 96.0% |
| Ward 07 Acute Medical Unit and GP Unit (WP) | 91.0% | 96.7% | 86.5% | 93.5% | 82.3% | 95.6% | 84.7% | 103.1% | 87.9% | 92.3% | 83.5% | 87.5% |
| Ward 09 General Medicine (WP) | 95.1% | 109.3% | 96.8% | 88.5% | 95.8% | 111.1% | 98.9% | 111.7% | 98.4% | 102.3% | 91.6% | 100.0% |
| Ward 10 Surgical (WP) | 94.6% | 99.1% | 94.0% | 95.6% | 91.8% | 101.1% | 94.3% | 101.1% | 70.5% | 73.2% | 85.6% | 81.4% |
| Ward 11 Surgical (WP) | 99.3% | 100.8% | 95.2% | 92.7% | 93.1% | 99.0% | 100.4% | 111.1% | 100.0% | 100.6% | 98.3% | 92.3% |
| Ward 15 Eden (WP) | 92.7% | 100.0% | 84.7% | 100.0% | 84.2% | 98.9% | 85.5% | 98.9% | 77.5% | 97.8% | 79.0% | 97.8% |
| Ward 17 General Medicine (WP) | 107.3% | 115.1% | 112.9% | 125.8% | 97.5% | 107.8% | 89.2% | 96.8% | 80.8% | 88.9% | 75.0% | 96.8% |
| Ward 18 General Medicine (WP) | | | | | 91.8% | 98.9% | 92.7% | 100.0% | 97.9% | 98.9% | 96.9% | 98.9% |
| Ward 20 Gynaelogy (WP) | 94.5% | 100.0% | 91.4% | 100.0% | 92.7% | 100.0% | 87.3% | 100.0% | 82.6% | 100.0% | 83.9% | 100.0% |
| Maternity Unit (WP) | 104.7% | 89.6% | 96.0% | 94.1% | 89.8% | 87.0% | 88.1% | 83.0% | 85.7% | 85.3% | 82.1% | 85.9% |
| Ward 24 Paediatric (WP) | 99.6% | 99.0% | 95.7% | 86.2% | 99.9% | 100.0% | 99.0% | 97.6% | 99.0% | 98.8% | 95.9% | 95.6% |
| Acute Stroke Unit (WP) | 91.7% | 95.5% | 89.4% | 91.0% | 83.3% | 106.0% | 85.8% | 103.4% | 89.1% | 95.7% | 91.1% | 98.9% |
| Christiansen Unit (WP) | 96.8% | 100.0% | 96.8% | 100.0% | 96.7% | 100.0% | 106.6% | 39.0% | 100.0% | 101.7% | 96.8% | 103.2% |
| Coronary Care Unit (WP) | 102.3% | 103.2% | 71.4% | 79.0% | 99.4% | 107.2% | 85.9% | 86.3% | 110.9% | 103.9% | 97.1% | 100.0% |
| Intensive Treatment Unit (WP) | 100.8% | 91.5% | 102.3% | 92.4% | 109.3% | 100.3% | 112.5% | 97.5% | 107.7% | 95.6% | 97.5% | 89.6% |
| Neonatal Unit (WP) | 108.1% | 106.5% | 124.2% | 116.1% | 120.5% | 113.3% | 120.1% | 128.7% | 99.9% | 100.7% | 93.6% | 95.7% |

Vacancies (after recruitment) Appendix 3

**Wexham Park**

| Ward | Speciality | No of Beds | Vacancies RN wte | Vacancies HCA wte |
|---|---|---|---|---|
| AMU & GP Unit | Acute Admissions | 64 +12 | 42.2 | 0 |
| Ward 2 | Medicine | 24 | 2 | 0 |
| Ward 3 | Elderly/Gen Med | 24 | 5 | 0 |
| Ward 4 | Cardiology | 28 | 5.57 | 2.8 |
| Ward 5 | Elderly | 36 | 9.46 | 0 |
| Ward 6 | Gastroenterology | 36 | 12.86 | 0 |
| Ward 9 | Respiratory | 42 | 12.4 | 1.2 |
| Ward 17 | Elderly | 28 | 0 | 10 |
| Ward 18 | Elderly | 26 | 14.59 | 1.23 |
| A&E | Emergency Care | | 26.83 | 0 |
| CCU | Coronary Care | 14 | 0 | 0 |
| Eden/ Day Unit | Oncology/Haematology | 17 | 4.20 | 2.10 |
| Acute Stroke Unit | Stroke | 25 | 7.93 | 0.67 |
| Ward 20 | Gynaecology | 22 | 4.36 | 1.16 |
| Ward 1 | Orthopaedics | 40 | 14.88 | 5 |
| Ward10 | Gen Surgery | 26 | 1 | 0 |
| Ward 11 | ENT/Max fax/Plastic | 23 | 0 | 0 |
| Christiansen | Gen Surgery | 16 | 1 | 1 |
| Paragon | Private Patients | 17 | 3 | 3 |
| W 1 Heatherwood | SSS | 10 | 0 | 0 |
| W 4 Heatherwood | El Orthopaedics | 24 | 0 | 0 |
| ITU | Emergency Care | 10 | 7.4 | 0 |
| Ward 24 | Paediatric | 37+5 | 14.68 | 5.58 |
| | | Total | 189.36 | 33.74 |

**Frimley**

| Ward | Speciality | No of Beds | Vacancies RN | Vacancies HCA |
|---|---|---|---|---|
| F1 | Paediatric | 25+5 | 9.14 | 0 |
| F11 | Gynae | 16 | 7.78 | 5.39 |
| F2 | Acute Elderly | 18 | 3.09 | 1 |
| F3 | Endocrinology | 36 | 0.39 | 1 |
| F9 | Gastroenterology | 32 | 4.19 | 2 |
| F10 | Gastro Escalation | 13 | 0.95 | 1.5 |
| F14 | Elderly | 17 | 2.66 | 1.72 |
| F15 | Gen Med | 12 | 0.16 | 2.24 |
| G1 | Haematology | 17 | 1.18 | 1.67 |
| G2 | Elderly | 31 | 1.12 | 0 |
| G3 | Stroke Unit | 28 | 4.53 | 3.14 |
| G5 | Respiratory | 48 | 4.96 | 1 |
| G9 | Cardiology | 32 | 3 | 0 |
| CCU | Cardiology | 12 | 2.61 | 1.25 |
| MADU | Acute Dependency Unit | 8 | 0.39 | 1.4 |
| MAU/AMU | Assessment Unit | 37 | 4.6 | 1.5 |
| CFU | Cystic Fibrosis | 5 | 0.47 | 0 |
| F4 | Trauma | 29 | 3 | 1 |
| F5 | #NOF | 26 | 2 | 1 |
| F6 | El Orthopaedics | 34 | 1 | 1 |
| F7 | Gen Surgery/Urology | 32 | 1 | 1 |
| F8 | Gen Surgery/Vascular | 31 | 1 | 1 |
| SADU | ADU | 7 | 0 | 0.3 |
| SAU | Assessment Unit | 12 | 1 | 0 |
| SSS | ENT/Breast | 17 | 2 | 1 |
| ICU | Critical care | 12 | 7.7 | 1 |
| Parkside | Private Patients | 37 | 6,2 | 1.5 |
| A&E | Emergency Care | | 2.0 | 0 |
| | | Total | 78.12 | 33.61 |

Frimley Health NHS
NHS Foundation Trust

# Specials Study Day

## 19th October 2015

**AM— Pine House Training Room**

| Time | Area to be covered | Facilitator |
|---|---|---|
| 08:30-08:45 | Welcome and Introduction | Emma Jones |
| 08:45-10:15 | Defining Dementia/Delirium/ Psychosis | AblenDacalos |
| 10:15-10:30 | Coffee | |
| 10:30-11:00 | Safeguarding | Evelyn Murillo |
| 11:00-11:45 | Managing Difficult Behaviour | Emma Jones |
| 11:45-12:30 | Meaningful Activities | |
| 12:3013:00 | Lunch | |

**PM—QuEST Simulation Suite**

| Time | Area to be covered | Facilitator |
|---|---|---|
| 13:00-13:30 | Managing Alcohol and Drug withdrawal | Hilary Naudi |
| 13:30-14:30 | Emotional Resilience | Emma Jones |
| 14:30-16:00 | Scenarios and Role Play | |
| 16:00-16:30 | Workbooks and Evaluation | |

Frimley Health NHS
NHS Foundation Trust

| | |
|---|---|
| Report Title | **2015/16 CIP Summary for HEB– Month 10** |
| Agenda Number | (to be completed by Company Secretariat) |
| Report type | Note. |
| Prepared by | Michael McEvoy, Business Support Accountant<br>Paula Bensley, Head of the Project Management Office |
| Executive Lead | Helen Coe, Director of Operations, FPH<br>Lisa Glynn, Director of Operations, HWPH |
| Executive Summary | To provide assurance regarding:<br>• Progress made to deliver the **£21.4** of CIP required in 2015/16.<br>• Progress made to deliver the **£2.35m** of Synergies required in 2015/16.<br>• Progress made to identify additional recurrent schemes to reduce the Trust to less than **<£10m** in year deficit. |
| Background | **Annual CIP Programme**<br>• The Trust CIP target for 2015/16 is **£21.4 m** excluding income schemes of £0.9m.<br>• As at 23rd September 2015, operational teams have validated **£25m** of schemes (core and additional). |
| Issues and Options | **1. CIP Programme Performance**<br>(Core & Additional Schemes)<br>• Month 10: the Trust has delivered **93% (£1.931m)** of the total planned position of **£2.076m** . A variance of **-£145k (6.99%).** .<br>• Year to date: the Trust has achieved **94%** (**£19.664m)** of the total planned position of **£20.912m**. A variance of **-£1.247m.**<br>Key points to note:<br>• Temporary staffing YTD performance has slightly improved delivering £6.984m, 87% of planned (a variance of **-£1.083m**). Schemes which rely on recruitment are at risk. Action to improve this position are being taken ie reviewing nursing turnover, review of exit interviews to ensure reasons for leaving are understood. In addition, sub-groups of the Operational Work Force Group have been established to review and develop new ways of working eg implementation of new roles eg Physician Assistants, Band 4 nurses/Nursing Assistants, Pharmacy Prescribers.<br>• ATCC: Job planning scheme behind schedule, delay in nursing recruitment and agency premium costs being incurred for nursing and ODPs.<br>• Ops WPH: Non Emergency Patient Transport underperformance.<br>• Orthopaedics and Plastics: Agency spend in at HWP exceeded vacant posts. Overspend being addressed by the use of additional controls.<br>• Estates: Delay in realising additional income from the additional visitor parking spaces – not yet in use. |
| Recommendation | The Board is asked to note the content of this report; progress made, and continued focus. |
| Appendices | 2015/2016 CIP Summary Performance Report– Month 10. |

Frimley Health NHS
NHS Foundation Trust

# *2015/16 CIP Summary – Month 10*

**CIP and Synergies summary for the Board**

**Updated position as at Wednesday 24th February 2016**

# Status Wednesday 24th February 2016 - Corporate View

**Annual CIP Programme**

- At Month 10, the Trust has delivered **£1.718m** of cost improvement against the plan in month of **£1.827m**.
- At Month 10, the year to date CIP delivery against plan is **-£1,086k** (or -**5.78%**) against a year to date plan of **£18.781m**; this is mainly due to:-
  - Temporary staffing costs have reduced as expected due to delays in recruitment of overseas staff which has meant the vacancy rate has remained a continued challenge for the trust.
- There is a continued risk to the delivery of those schemes that rely on the recruitment of nursing staff. This is as a result of challenges relating to overseas recruitment. A Nursing and Midwifery Dashboard has been developed which is a bi-weekly report that brings together vacancy levels, turnover rates and recruitment information. This report will help Heads of Nursing to review the status of wards in terms of key workforce indicators.
- Forecast Outturn is **£19.9m** or **90%** achievement on schemes valued at £22.4m

**Additional CIP Schemes to reduce Trust Deficit**

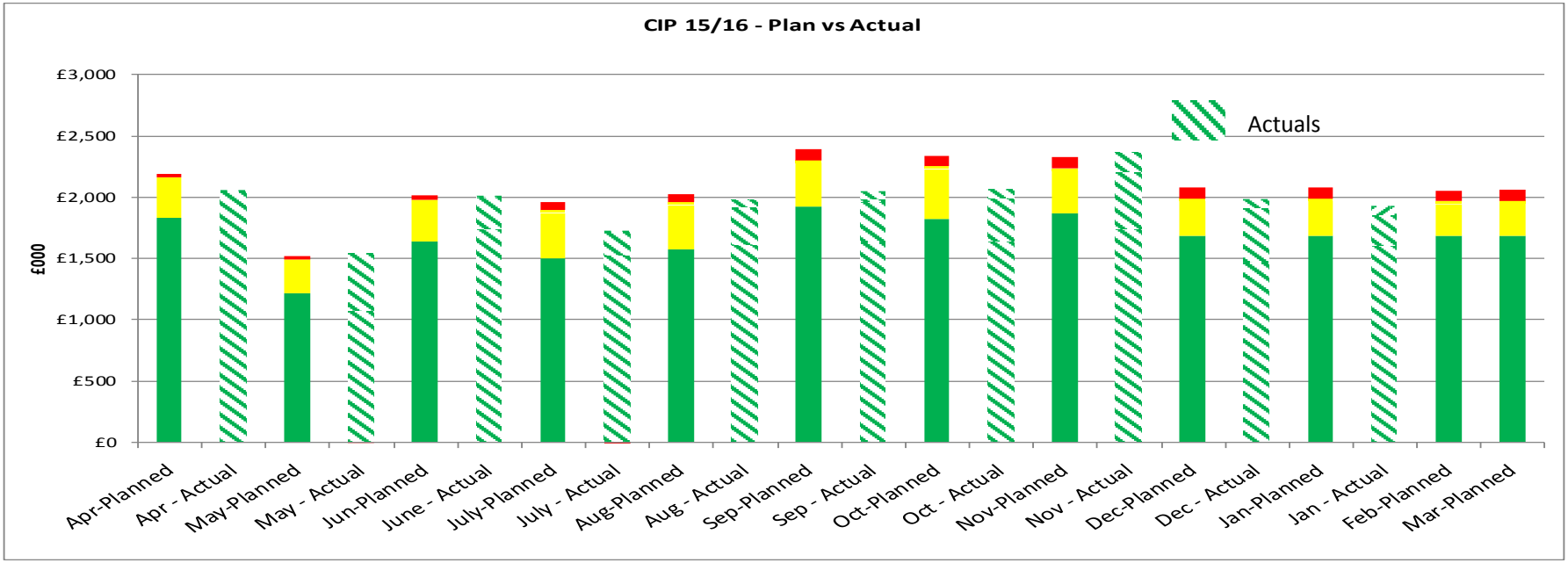
- The trust has identified a further **£3.1m risk adjusted** schemes to reduce the in year deficit.
- At Month 10, the year to date delivery against **£2.6m** additional CIP schemes is **£1,970k** which represents a variance from plan of **-£161k** (or **-7.55%)**
- Forecast Outturn is **£2.5m** or **96%** achievement on schemes valued at £2.6m

**Synergies**

- The synergy target for 2015/16 is £2.35m
- The forecasted outturn as at Month 10 is £1.9m, although this is largely due to slippage of schemes rather than expectation that the schemes will not be delivered at all.

# Trust Overview – 2015/16 Total CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| **£21.4m** | **£25m** | **£2.076m** | **£1.931m** | **-£0.145m** | **£20.912m** | **£19.664m** | **-£1.247m** |



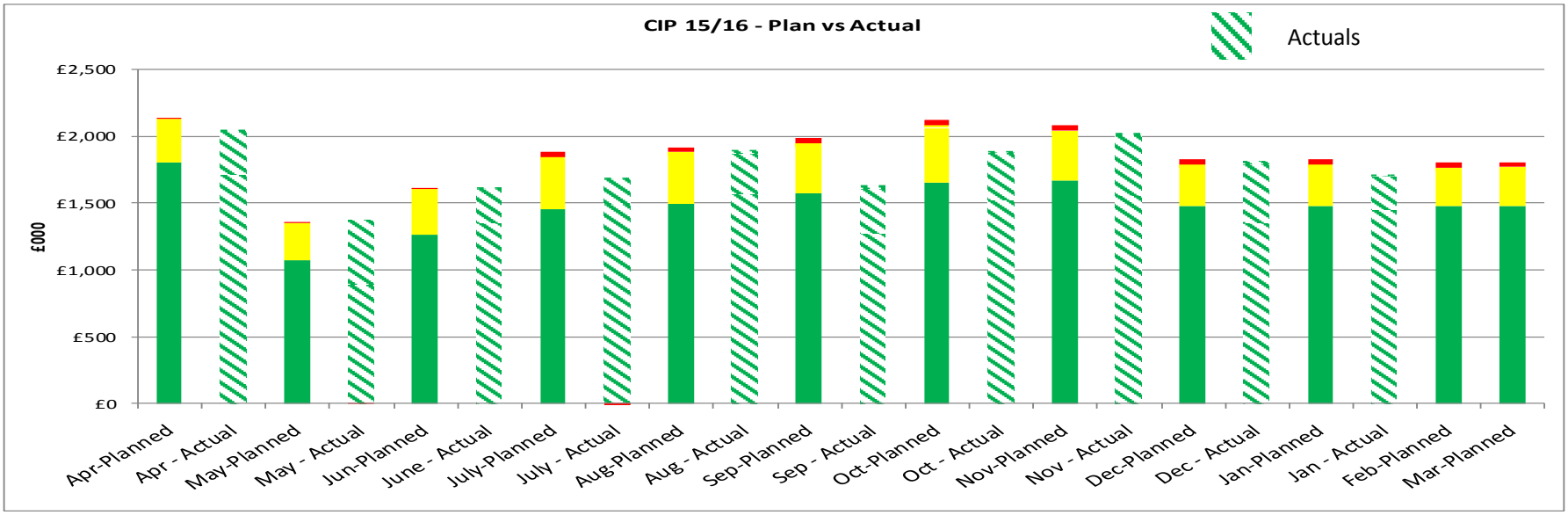

► At Month 10, the Trust has delivered **£1.931m** of cost improvement against the in- month plan of **£2.076m** – which represents a variance from plan of **-£145k** (or **-6.99%**)

► At Month 10, the year to date delivery against **£20.912m** total CIP schemes is **£19.664m** which represents a variance from plan of **-£1.247m**(or **-5.96%**)

All values in £000

# Trust Overview – 2015/16 Core CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| £21.4m | £22.4m | £1.827m | £1.718m | -£0.109m | £18.781m | £17.694m | -£1.086m |

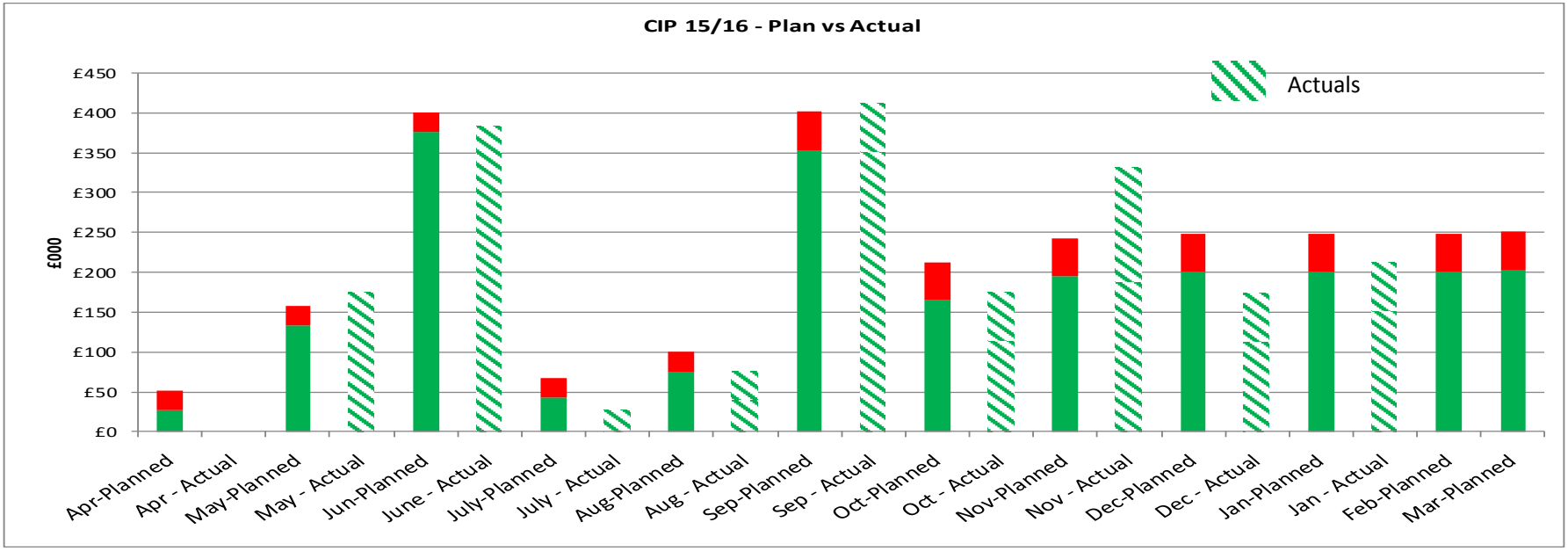



- At Month 10, the Trust has delivered **£1.718m** of cost improvement against the plan in month of **£1.827m**.
- At Month 10, delivery against plan is **-£109k for January.**
- At Month 10, the year to date CIP delivery against plan is **-£1.086m** (or **-5.78%**) against a year to date plan of **£18.781m**.

All values in £000

# Trust Overview – 2015/16 Additional CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| £3.1m | £2.6m | £0.249m | £0.213m | -£0.036m | £2.131m | £1.970m | -£0.161m |




► At Month 10, delivery against plan is an under achievement of -£36k for January.

► At Month 10, the year to date delivery against **£2.6m** additional CIP schemes is **£1.970m** which represents a variance from plan of **-£161k** (or **-7.55%**)

All values in £000

# Additional schemes to reduce the in-year deficit <£10m

## Scheme detail and financial value

| Description | Responsible Officer | Gateway | PYE Plan £000s | FYE Plan £000s | Risk adjusted £000s | Plan at M06 £000s |
|---|---|---|---|---|---|---|
| Bring H & WP staffing ratios in line with FPH (1:8/1:10) | Helen Crick/Liz Howells | 5 | £168 | £336 | £168 | £168 |
| Additional catering income | Mark Johnson Wood | 5 | £93 | £93 | £93 | £93 |
| Catering Income | Mark Johnson Wood | 5 | £120 | £120 | £120 | £120 |
| Endoscopy WLI reduction from 2014/15 outturn of £1m | Liz Howells | 5 | £333 | £400 | £333 | £333 |
| Replacement of agency respiratory technician with substantive staff | Ruth Colburn-Jackson | 5 | £325 | £325 | £325 | £325 |
| Orthopaedic Middle Grades | Catherine Johnson | 5 | £70 | £70 | £70 | £70 |
| Plastics Rota | Catherine Johnson | 5 | £108 | £108 | £108 | £108 |
| WPH Admin Reduction if premium costs in Parapet | Liz Howells | 5 | £89 | £89 | £89 | £89 |
| WPH Admin Reduction in premium cost in Cancer Services | Liz Howells | | | | | |
| Reduction in agency spend in Ward 11 | Liz Howells | 5 | £100 | £100 | £100 | £100 |
| Reduction in agency spend in Ward 10 | Liz Howells | | | | | |
| Reduction in agency spend in CU | Liz Howells | | | | | |
| Reduction in agency spend in Corporate Nursing | Nicola Ranger | 5 | £30 | £30 | £30 | £30 |
| General Surgery - SAU relocation WPH | Liz Howells | 5 | £329 | £493 | £329 | £329 |
| HR Department | John Ireland | 5 | £50 | £50 | £50 | - |
| Anaesthetics Specialty Doctors | Catherine Johnson | 5 | £250 | £250 | £0 | £250 |
| Reduction in agency in Anaesthetics | Catherine Johnson | 5 | £47 | £47 | £0 | £47 |
| Spinal Cord Stimulation Service | Catherine Johnson | 5 | £163 | £280 | £0 | £163 |
| HR Schemes (various) | Janet King | 5 | £100 | £100 | £0 | - |
| Community Paediatric Service | Kirstin McDonald | 5 | £100 | £100 | £0 | - |
| Reduction in run-rate costs in Dir of Ops Budget | Lisa Glynn | 5 | £34 | £34 | £34 | £34 |
| Reduction in admin costs in 18 Week Team | Lisa Glynn | 5 | £20 | £20 | £20 | £20 |
| Reduction in agency spend in Discharge Team | Mary Wells | 5 | £50 | £50 | £50 | £50 |
| Occupational Health Contract | Eleanor Singleton-Smith | 5 | £50 | £50 | £50 | £50 |
| NHSP Contract | John Ireland | 5 | £250 | £250 | £250 | £250 |
| ED Medical Staffing | Helen Crick | 5 | £750 | £750 | £750 | - |
| SAU relocation WPH | Liz Howells | 5 | £164 | £0 | £164 | - |
| **TOTAL** | | | **£3,793** | **£4,145** | **£3,133** | **£2,629** |

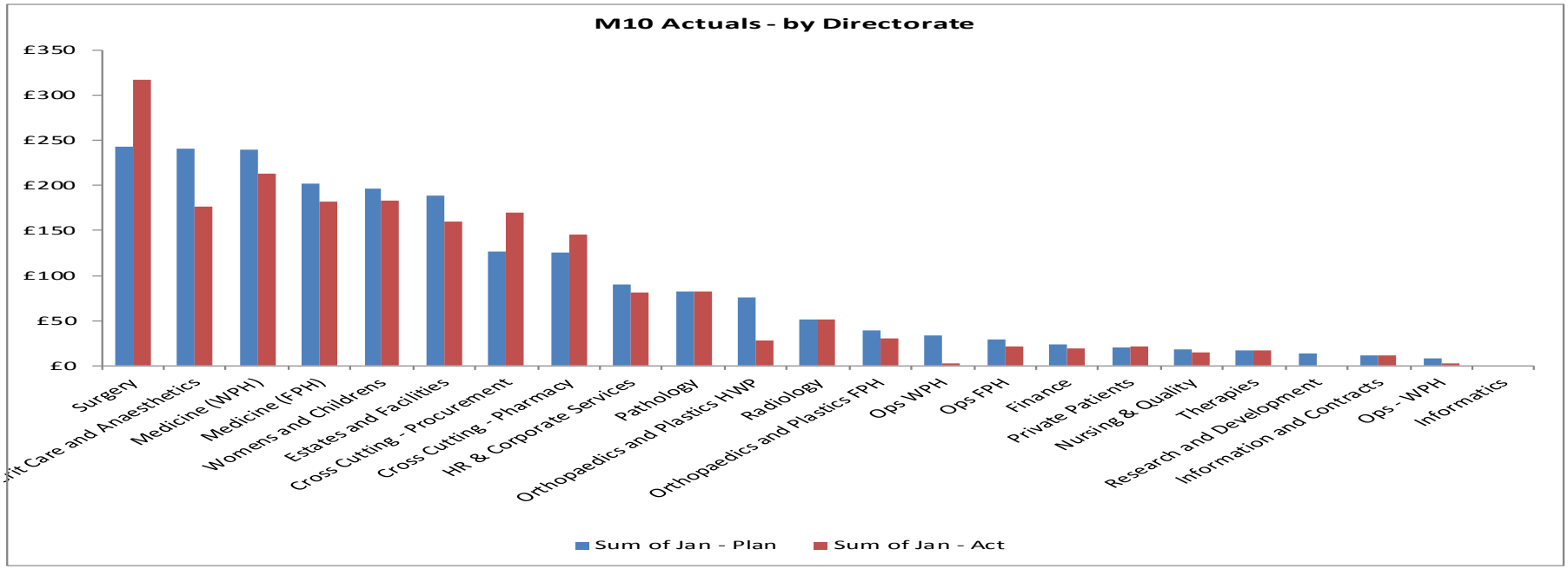
The table adjacent provides a validated position on additional CIP schemes identified to reduce the in year deficit.

The part year effect of schemes totals £3.8m.

The schemes identified in red require a lead in time for delivery and will be supported in year by integration funding.

# M10 Actual (All Schemes) – By directorate

**Month 10 Plan = £2.076m**
**Month 10 Actual = £1.931m**

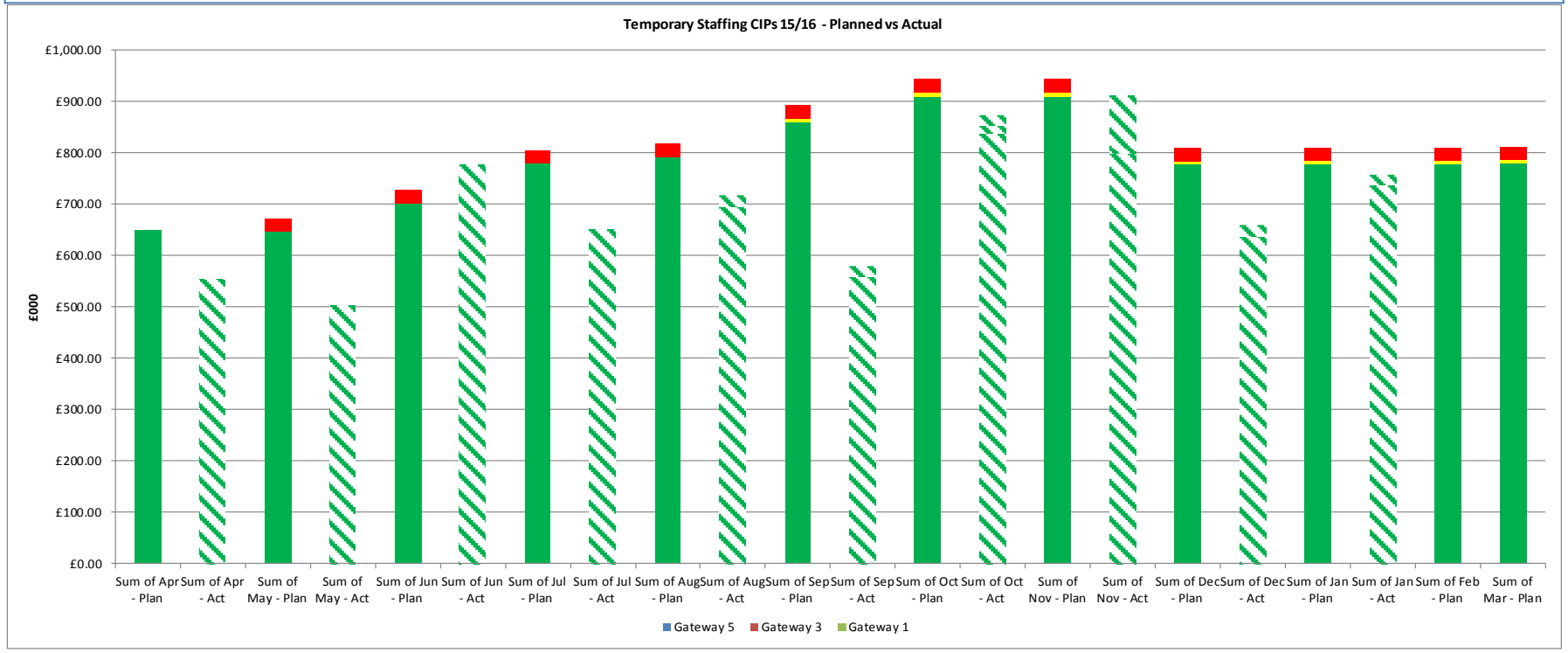



- The graph above shows the CIP delivery in Month 10 by Directorate. The graph shows actual delivery against planned profile agreed at the beginning of the year.
- There are 14 Directorates/Departments showing an underperformance against plan in Month 10.
- The Directorates are now required to complete a CIP exception report (by scheme) and associated remedial action plan for review and scrutiny at their monthly Directorate Performance Review Meetings.
- The over achievement of Surgery is due to reduction in nursing agency expenditure and improved medical consumables ordering.

All values in £000

# Month 10 Performance - Temporary Staffing (All Schemes)

| Total CIP Value | Plan - Jan | Actual - Jan | Jan Variance | Plan - YTD | Actual - YTD | YTD Variance |
|---|---|---|---|---|---|---|
| £9,694.00 | £809.48 | £758.08 | -£51.40 | £8,067.31 | £6,984.44 | -£1,082.87 |

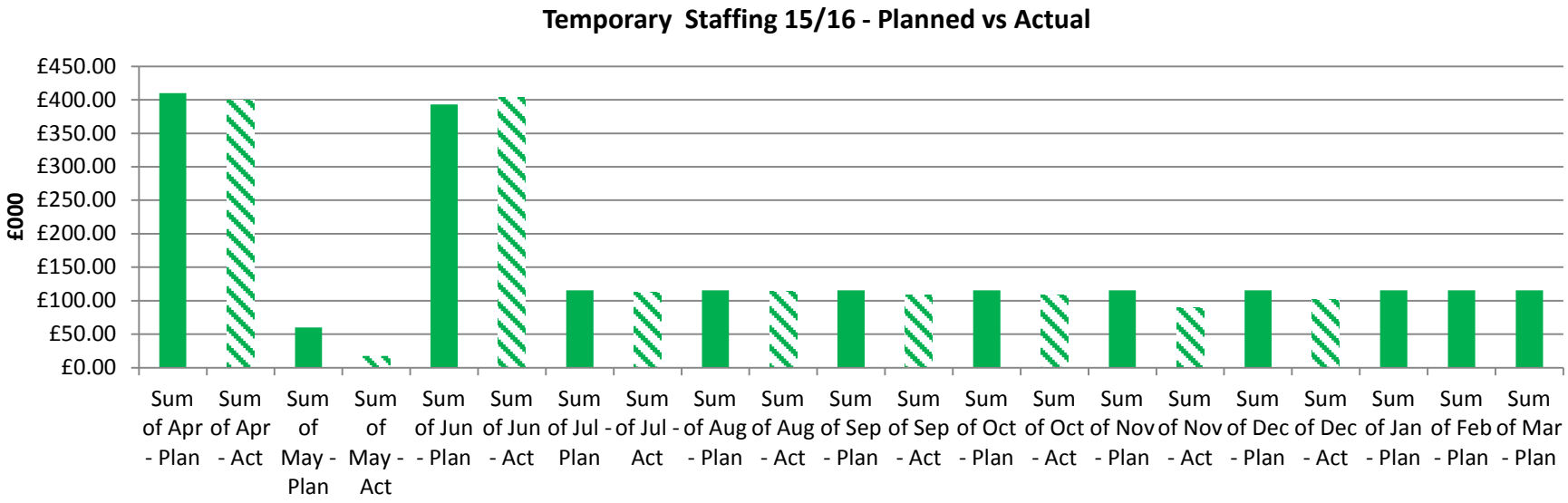



- Within the CIP Programme for 2015/16, 32 'temporary staffing' schemes account for **£9.7m** of the **£25m** of schemes identified.
- In Month 10 (January), the trust has delivered **£758k** against a plan of **£809k**. This is an under achievement **-£51k**. (or **-6.34%**)
- Year-to-date, the temporary staffing schemes have delivered **-£1,082k** less than plan (or **-13.4%**)
- There is a risk to the delivery of those schemes that rely on the recruitment of nursing staff. This is as a result of challenges relating to overseas recruitment. Remedial action plans are being developed and a full assessment of the financial risk is currently being identified.

All values in £000

# Month 10 Performance - Waiting List Initiatives

| Total CIP Value | Plan - Jan | Actual - Jan | Jan Variance | Plan - YTD | Actual - YTD | YTD Variance |
|---|---|---|---|---|---|---|
| £1,902.00 | £115.47 | £85.00 | -£30.47 | £1,671.02 | £1,537.32 | -£133.70 |




- The trust has identified total savings of £1.5m of WLI schemes
- In Month 10 (January), the trust has delivered £85k against a plan of £115k
- This is an under achievement of -£30k
- Year-to-date, WLI schemes are behind by -£133k. (or 8%) .

All values in £000

# Trust Overview – Synergies 2015/16

| Workstream/Directorate | 2014/15 | 2015/16 | Additional Comments |
|---|---|---|---|
| Chief Exec & Corporate | 686 | 686 | Delivered |
| Procurement | 0 | 400 | |
| Pharmacy | 23 | 167 | |
| Nursing & Quality | 86 | 86 | |
| Radiology | 26 | 60 | One scheme has been achieved in Nov 14 and will be a part year effect. Another scheme is delayed until Dec 15 |
| HR | -127 | 23 | All schemes confirmed as on track. |
| Dir of Ops | 20 | 360 | Delivered |
| Contracting & Information | 0 | 138 | Expected in Q3 – Will be a part year effect |
| Estates & Facilities | 0 | 175 | Expected in Q3 – Will be a part year effect |
| Finance | 15 | 147 | This scheme is at risk of slippage due to the delay in the implementation of a single ledger across all sites. This is unlikely to delivery savings before Q4 for 15/16 and therefore should be considered a part year effect. |
| Informatics | 0 | 109 | The £109k is split into two areas. 1) IT infrastructure of £91k which is subject to slippage and not expected to deliver in 15/16. 2) £18k relating to new ways of working which is dependent on infrastructure being delivered and unlikely to deliver in year. |
| **Grand Total** | **729** | **2,350** | |

Delivered

In-Progress or part year effect only

At risk of non delivery in year

- Finance Pay underspend mitigating Synergy slippage in year. The ledger implementation has been fast tracked & it is anticipated that post implementation will deliver remaining synergy
- In 2014/15, the trust delivered £729k of synergies
- The synergy target for 2015/16 is £2.35m
- The position as at Month 10 shows £1.78m green, £460k amber and £109k at risk of non delivery in year.

All values in £000

# Key next steps

- Focus on delivery of remedial actions for schemes that are under delivering against plan.
- Review documentation of the PMO schemes and ensure it is up-to date.
- Continue to drive the delivery of additional schemes to reduce the deficit to <£10m gap.

Frimley Health NHS
NHS Foundation Trust

| | |
|---|---|
| Report Title | **2016/17 CIP Schemes - Gateway Progress Update** |
| Agenda Number | (to be completed by Company Secretariat) |
| Report type | Note. |
| Prepared by | Hugh Cronshey<br>Paula Bensley, Head of the Project Management Office |
| Executive Lead | Helen Coe, Director of Operations, FPH<br>Lisa Glynn, Director of Operations, HWPH |
| Executive Summary | To provide assurance regarding the progress made to progress the 16/17 CIP schemes through the Gateway process. |
| Background | **16/17 CIP Development Programme**<br><br>In November 2015, EY identified CIP opportunities to the value of £24.3m with a risk adjusted value of 5.5m against an initial target of £26.1m. |
| Issues and Options | Directorates have been working with their BSAs to validate the CIP opportunity and progress their CIP schemes through the gateways. Although the total identified in February is now £22.4m, the risk adjusted value has increased to £8.5m.<br><br>There are a further 16 schemes which are now at gateway 3 that have not been included in this update due to timing issues.<br><br>The PMO is working with ADs and HoS to develop “root to cash” project plans to enable these schemes to move to gateways 4 and 5.<br><br>Those schemes which are still at gateway 1 are being addressed with ADs and HoS via the Financial Directorate Reviews. |
| Recommendation | The Board is asked to note the content of this report; progress made, and continued focus. |
| Appendices | 2016/201 CIP Development Report. |

Frimley Health NHS
NHS Foundation Trust

# 2016/17 CIP Progress Update

## As at Thursday 25th February 2016

***CIP pack v 2.9***

# Progress Update

Headline numbers at the point of Hand Over from EY

| Target for 16/17 | Total Identified | Gap | Risk Adjusted Value |
|---|---|---|---|
| £26.1m | £24.3m | -£1.8m | £5.5m |

Headline numbers as at 16/11/2015

| Target for 16/17 | Total Identified | Gap | Risk Adjusted Value |
|---|---|---|---|
| £26.1m | £24m | -£2.1m | £6.8m |

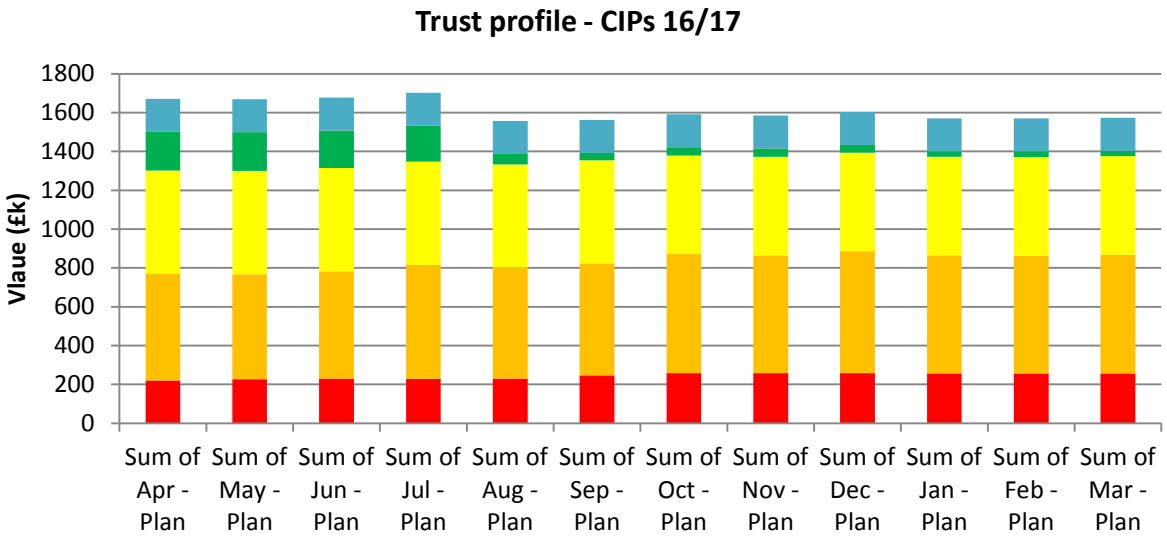
Headline numbers as at 16/11/2015

| Target for 16/17 | Total Identified | Gap | Risk Adjusted Value |
|---|---|---|---|
| £26.1m | £22.4m | -£3.7m | £8.5m |

Total Identified has reduced by £1.6m. The RA value has improved by £1.7m

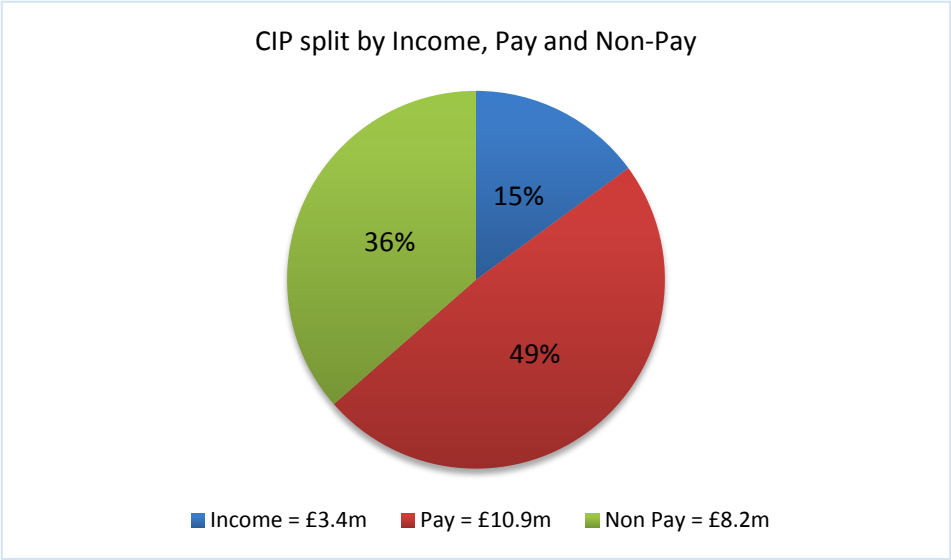
# Movements Since Nov Update:

| Ref | Title | Directorate | Total (£k) | V2 7 | Movment: | Notes |
|---|---|---|---|---|---|---|
| 1.19 | Reduction Endoscopy WLI | Surgery | 267 | 67.00 | 200 | |
| 1.46 | Reduction General Surgery WLI | Surgery | 30 | 300.00 | (270) | |
| 1.68 | Reduction Ophthalmology WLI | Surgery | 70 | - | 70 | |
| 3.12 | CCG contract PYE 6 months | Medicine (WPH) | | 190.00 | (190) | Forms part of the QIPP/Growth Negotiations |
| 3.16 | LoS review to achieve bed redu | Medicine (WPH) | 750 | 1,125.00 | (375) | Down rated at Dec Fin Performance |
| 9.16 | PP recharging for consumables | Theatres, Crit Care and Anaesthetics | | 300.00 | (300) | Scheme removed by AD |
| 9.23 | Monitor Agency cap reduction | Theatres, Crit Care and Anaesthetics | | 194.00 | (194) | Scheme removed by AD |
| 15.23 | Energy Procurement Contract | Estates and Facilities | | 200.00 | (200) | Can't terminate the contract this financial year |
| 15.31 | Cleanliness | Estates and Facilities | | 287.70 | (288) | Working Party set up to determine cleaning strategy |
| 15.36 | Portering | Estates and Facilities | | 100.00 | (100) | Requires more work to agree the best approach |
| 17.27 | Extend staff flow to cover AHPs | HR & Corporate Services | 78 | 48.00 | 30 | |
| | | | | | **(1,617)** | |

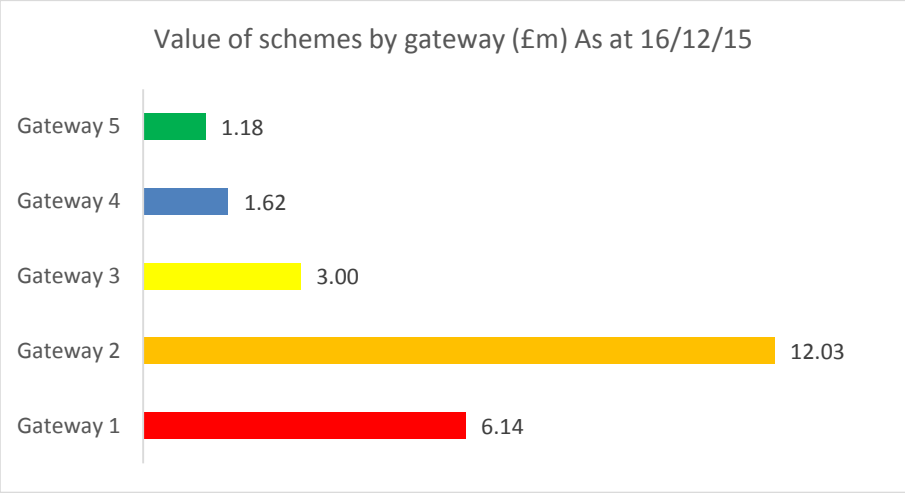


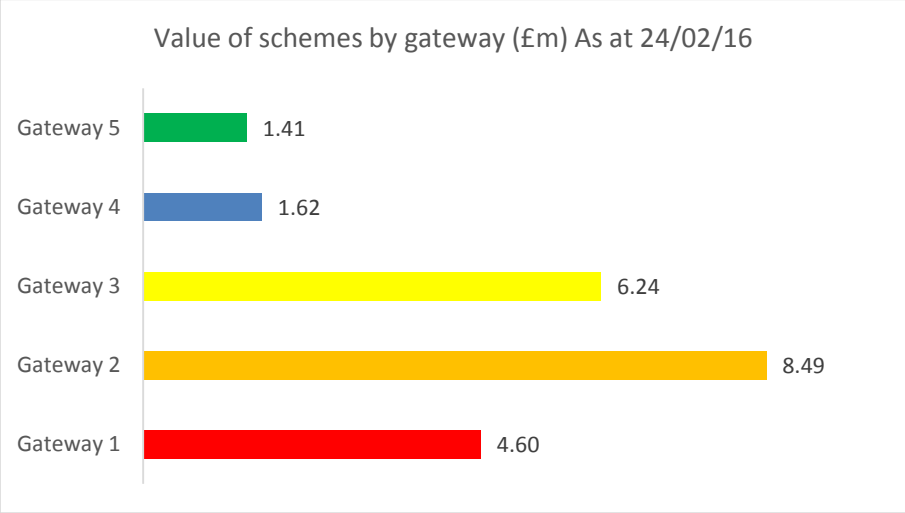

The schemes are profiled fairly evenly through the financial year, however are still over 80 schemes that need to be profiled.

The proportion of pay related CIPS has reduced from 52% to 49%.



# Progress Through the Gateways:




The Finance & PMO teams have worked to push the schemes through the gateways. The value of schemes in gateway 3 has doubled. There are 23 schemes left in Gateway 1.

| Directorate | Sum of Total (£k) | No. |
|---|---|---|
| Estates and Facilities | 112 | 2 |
| HR & Corporate Services | 1,857 | 8 |
| Informatics | 240 | 1 |
| Medicine (FPH) | 246 | 1 |
| Medicine (WPH) | 519 | 2 |
| Nursing and Quality | 95 | 1 |
| Outpatient WPH | 23 | 1 |
| Pathology | 830 | 1 |
| Surgery | 17 | 1 |
| Theatres, Crit Care and Anaesthetics | 573 | 2 |
| Womens and Childrens | 87 | 3 |
| **Grand Total** | **4,599** | **23** |

| Directorate | Ref | Title | Sum of Total (£k) |
|---|---|---|---|
| Estates and Facilities | 15.24 | Energy Savings | 45 |
| | 15.40 | Catering saving | 67 |
| Estates and Facilities Total | | | 112 |
| HR & Corporate Services | 17.21 | Staff flow | 118 |
| | 17.25 | Expences policy | 30 |
| | 17.27 | Extend staff flow to cover AHPs Frimley and HWP | 78 |
| | 17.29 | Maternity Leave Business Partner | 10 |
| | 17.31 | Cap on Agency | 1,500 |
| | 17.32 | Introduction of IT system to book Internal Docs at Frimley (bank) | 100 |
| | 17.33 | Staff Counselling | 5 |
| | 17.34 | Company Secretary | 16 |
| HR & Corporate Services Total | | | 1,857 |
| Informatics | 18.11 | IT Department staffing | 240 |
| Informatics Total | | | 240 |
| Medicine (FPH) | 2.59 | Monitor Agency cap reduction | 246 |
| Medicine (FPH) Total | | | 246 |
| Medicine (WPH) | 3.23 | Productivity review (workforce) | 250 |
| | 3.24 | Monitor Agency cap reduction | 269 |
| Medicine (WPH) Total | | | 519 |
| Nursing and Quality | 19.16 | Transfer of post to cardio clinics | 95 |
| Nursing and Quality Total | | | 95 |
| Outpatient WPH | 4.29 | Provision of space on the WPH OPD site for OOH service | 23 |
| Outpatient WPH Total | | | 23 |
| Pathology | 6.11 | SPS business case | 830 |
| Pathology Total | | | 830 |
| Surgery | 1.59 | Charge for private cancer patients discussed at Multi Disciplinary Team meetings | 17 |
| Surgery Total | | | 17 |
| Theatres, Crit Care and Anaesthetics | 9.17 | Review of stock control process cross site and move to lean methodology | 450 |
| | 9.19 | Restructure of Pre-op slots at FPH | 123 |
| Theatres, Crit Care and Anaesthetics Total | | | 573 |
| Womens and Childrens | 11.25 | BADS to OPPROC: One stop gynaecology clinics OPROC hysteroscopy | 35 |
| | 11.33 | Non-pay budget review | 50 |
| | 11.35 | Increasing the price of baby scans | 2 |
| Womens and Childrens Total | | | 87 |
| Grand Total | | | 4,599 |

Progress Through the Gateway 1

# Directorate Headline Positions:

| Directorate | Target (£m) | Identified schemes (£m) | Pharmacy redistribution (£m) | Procurement redistribution (£m) | Total value of schemes (£m) | Variance (£m) |
|---|---|---|---|---|---|---|
| Education | 0.13 | 0.10 | 0.00 | 0.00 | 0.10 | -0.04 |
| Estates and Facilities | 1.70 | 1.20 | 0.00 | 0.06 | 1.26 | -0.44 |
| Finance | 0.15 | 0.16 | 0.00 | 0.00 | 0.16 | 0.01 |
| HR & Corporate Services | 0.30 | 1.86 | 0.00 | 0.01 | 1.86 | 1.56 |
| Informatics | 0.33 | 0.24 | 0.00 | 0.01 | 0.25 | -0.08 |
| Information and Contracts | 0.19 | 0.16 | 0.00 | 0.00 | 0.16 | -0.03 |
| Medicine (FPH) | 2.90 | 2.50 | 0.92 | 0.55 | 3.97 | 1.07 |
| Medicine (WPH) | 5.45 | 2.57 | 0.69 | 0.66 | 3.92 | -1.53 |
| Nursing and Quality | 0.24 | 0.27 | 0.00 | 0.01 | 0.28 | 0.04 |
| Ops FPH | 0.15 | 0.00 | 0.00 | 0.00 | 0.00 | -0.15 |
| Ops WPH | 0.23 | 0.14 | 0.00 | 0.01 | 0.14 | -0.09 |
| Orthopaedics and Plastics | 1.79 | 1.12 | 0.00 | 0.15 | 1.26 | -0.53 |
| Outpatient FPH | 0.25 | 0.08 | 0.00 | 0.01 | 0.08 | -0.17 |
| Outpatient WPH | 0.19 | 0.12 | 0.00 | 0.00 | 0.13 | -0.06 |
| Pathology | 1.42 | 0.83 | 0.00 | 0.05 | 0.88 | -0.54 |
| Patient records WPH | 0.19 | 0.00 | 0.00 | 0.00 | 0.00 | -0.19 |
| Pharmacy | 0.36 | 0.00 | 0.00 | 0.01 | 0.01 | -0.35 |
| Radiology | 1.15 | 0.51 | 0.00 | 0.04 | 0.55 | -0.60 |
| Surgery | 2.70 | 2.48 | 0.42 | 0.18 | 3.09 | 0.39 |
| Theatres, Crit Care and Ana | 3.03 | 2.54 | 0.14 | 0.14 | 2.82 | -0.21 |
| Therapies | 0.79 | 0.36 | 0.00 | 0.03 | 0.38 | -0.41 |
| Womens and Childrens | 2.87 | 0.85 | 0.11 | 0.11 | 1.07 | -1.80 |
| **Grand Total** | **26.51** | **18.06** | **2.30** | **2.03** | **22.39** | |

# CIPS & The Annual Plan

| | V2.9 | Annual Plan | Proportion |
|---|---|---|---|
| Enabling costs (£k) | 112.0 | 112.0 | 100% |
| Income (£k) | 3,355.8 | 1,484.1 | 44% |
| Pay (£k) | 10,921.2 | 11,013.6 | 101% |
| Non Pay (£k) | 8,186.2 | 7,712.2 | 94% |
| **Total (£k)** | **22,351.2** | **20,097.9** | **90%** |

| | |
|---|---|
| Current CIP Performance | 94.22% |
| Which would be: | **21,059.3** |
| Under-delivery | (1,291.9) |

Assuming delivery similar to 2015/16 this would generate sufficient CIPS.

£4.6m in Gateway 1.

The Annual Plan is based on delivery of £20m CIPs.

- Discounted the schemes that generate additional NHS Clinical Income, as they need to be agreed with the Commissioners.
- Discounted the non-cash releasing schemes.

| Report Title | Month 10 Finance Report to The Board of Directors |
|---|---|
| **Date of Meeting** | 4th March 2016 |
| **Agenda Number** | 15. |
| **Report type** | To note the current and forecast financial position of the Trust |
| **Prepared by** | Edward John (Director of Operational Finance) |
| **Executive Lead** | Martin Sykes (Director of Finance) |
| **Executive Summary** | Performance is on track against the mid- year resubmission to Monitor. The run rate for pay expenditure and in particular agency spend continues to be flat and therefore the year end forecast deficit is still held at the revised plan level of £12m. However, additional support agreed with DH of £10m plus a revenue to capital transfer of £3m means the forecast declared position will be a surplus of £1m. The underlying position remains unchanged,<br>CCG Income is continuing to over perform and although 90% of Q1 and Q2 has been billed the Q3 and Q4 outturn remain to be confirmed. CCG income recovery is the largest risk to plan achievement. |
| **Background** | The Trust originally set a deficit budget of £14.2m for 2015/16 against which this report is monitored. In October 2015 a re-plan was submitted to Monitor and DH suggesting a £12m deficit is achievable. This report provides financial performance information in relation to the achievement of both the original and revised target deficit position and key dependent indicators including CIP, Cash and Capital. |
| **Issues and Options** | - Agency continues to be the main driver of overspend and is not reducing at the planned rate so although performance is at revised plan level the underlying position remains unchanged and requires continued cost base reduction.<br>- the CIP is profiled to deliver greater benefit in Q4 and is heavily dependent of recruitment and retention to reduce agency costs - this remains a key risk particularly as Feb has seen pressure on capacity. |
| **Recommendation** | The Board is asked to note the month 10 and forecast year end position. |
| **Appendices** | Finance and Commercial Board Report |

# Finance & Commercial Board Report

## January 2015

# Overall Summary

**Performance is on track against the mid- year resubmission to Monitor; run rate for pay expenditure including agency spend continues to be flat and so the year end forecast is held at the revised plan level of £12m. However, additional DH support of £10m plus a revenue to capital transfer of £3m means the forecast declared position will be a surplus of £1m.**

| Area | Key points | Action taken |
|---|---|---|
| **Income** | • Year-to-date operating income is £10.5m ahead of plan. The forecast variance on operating income is £12.2m (subject to confirmation with CCGs). Additional non recurrent support of £13m means that the Trust will declare a surplus of £1m at the y/e. | • CCGs settled on prior year outturn and have acknowledged overperformance. |
| **Expenditure** | • Operating expenditure is £10.7m over original plan ytd. Agency costs continue to be flat and non-pay has returned to expected levels after last months blip (catch up). Integration and transaction spend is £10.7m ytd which is matched to income on a spend-recover basis. | • Focus needs to continue on recruitment and ensuring rota's are delivered to plan |
| **Net surplus/ deficit** | • Broadly on plan in month but because of £13m agreed additional non-recurrent support the year end forecast is now £1m surplus. | • None not covered elsewhere |
| **CIPs** | • The Trust annual plan assumes delivery of a minimum of £21.4m of savings schemes. In month 10 the trust has delivered £2.0m of schemes against a plan of £1.9m<br>• Year to date £1.25m adverse -> £19.6m against a target of £20.9m.. | • None required at this stage |
| **Cash balance** | • in month £7.2m above a plan of £46.5m due largely to improvement in working capital i.e increase in payables. The forecast capital underspend plus the additional DH support of £10m due to be invoiced before the year end means the forecast y/e balance is now £13.7m above plan at £60.6m. | • Consideration on operation impact of capital slippage needed. Monies are available to carry forward. |
| **Capital expenditure** | • £2.9m under in month increasing the YTD under spend to £20.1m and hence a revision in the full year forecast to £23.5m against an original forecast of £41.2m. Slippage on the modular ward, car park and estates program (all at Wexham) comprise the main underspends. | • None as capital can be carried forward as long as essential infrastructure and equipment is maintained. |

# Income & Expenditure - Month 10 and Year to Date – Summary

| Frimley Health | Current Month | | | Year to Date | | | Full Year Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m |
| Income | 48.6 | 49.7 | **1.1** | 484.4 | 494.9 | **10.5** | 582.6 | 607.8 | **25.2** |
| Expenditure | (47.0) | (48.4) | **(1.4)** | (469.8) | (481.5) | **(11.7)** | (567.9) | (578.4) | **(10.5)** |
| Trust Financing | (2.5) | (2.4) | **0.1** | (23.9) | (23.8) | **0.1** | (28.9) | (28.4) | **0.5** |
| **Net Revenue Surplus / (Deficit)** | **(0.9)** | **(1.1)** | **(0.2)** | **(9.3)** | **(10.3)** | **(1.0)** | **(14.2)** | **1.0** | **15.2** |
| Integration Funding | 0.6 | 1.6 | **1.0** | 6.3 | 10.7 | **4.4** | 7.5 | 12.0 | **4.5** |
| Integration Costs | (0.6) | (1.6) | **(1.0)** | (6.3) | (10.7) | **(4.4)** | (7.5) | (12.0) | **(4.5)** |
| **Net Revenue Surplus / (Deficit) after one-off items** | **(0.9)** | **(1.1)** | **(0.2)** | **(9.3)** | **(10.3)** | **(1.0)** | **(14.2)** | **1.0** | **15.2** |

**Key messages:**

**Plan:** The Trust reported a £1.1m deficit for January, £200k higher than the planned £0.9m. The YTD deficit is £10.30m and is now £1m higher than the plan.

**Operating Income**: The trust had planned for £42m income from NHS Patient Activity and delivered £43m (2.75% favourable variance) . Other income has remained fairly stable compared to M09.

**Operating Expenditure**: Pay costs totalled £31.3m, which is £0.3m higher than last month and £0.5m over plan. Non-pay expenditure (including Trust Financing) was £19.5m, which is £1.9m lower than last month but £0.83m over plan. The main reduction being the drug costs, which was due to a one-off catch up last month.

***Forecasted Outturn:***

The forecasted outturn has been improved significantly, reflecting the additional deficit support from the DH (£10m) and the transfer of capital funding into revenue support (£3m). This has led to a revision of the forecast from £12m deficit to £1m surplus.

The underlying income and expenditure projections have also been revised upwards this month, acknowledging the continued pressure in the hospital.

# Income & Expenditure Month 10 – Subjective Analysis

**Trust Operations - Excluding Integration**

| I&E by Subjective Heading | Mth Bud £m | Month Act £m | Mth Var £m | YTD Var £m | Total Ann Bud £m |
|---|---|---|---|---|---|
| **Income** | | | | | |
| Income From Activities | (44.32) | (45.38) | (1.06) | (10.57) | (531.93) |
| Other Operating Income | (4.27) | (4.31) | (0.04) | 0.03 | (50.64) |
| **Income Total** | **(48.59)** | **(49.70)** | **(1.11)** | **(10.54)** | **(582.57)** |
| **Pay** | | | | | |
| Medical And Dental | 8.23 | 7.99 | (0.24) | (3.83) | 98.94 |
| Nursing & Midwifery | 9.26 | 8.90 | (0.36) | (5.53) | 111.18 |
| HCAs & Other Support Staff | 3.48 | 3.47 | (0.01) | 0.64 | 41.57 |
| AHPs, Prof, Scientific & Technical | 4.08 | 3.65 | (0.43) | 2.23 | 48.76 |
| Agency Staff External | 1.06 | 2.98 | 1.92 | 20.44 | 16.51 |
| Other Staff | 4.71 | 4.32 | (0.38) | (10.13) | 56.55 |
| **Pay Total** | **30.81** | **31.31** | **0.50** | **3.83** | **373.51** |
| **Non-Pay** | | | | | |
| Clinical Service And Supplies | 9.44 | 10.32 | 0.88 | 6.83 | 112.69 |
| General Supplies And Services | 0.65 | 0.63 | (0.02) | (0.20) | 7.75 |
| Premises & Fixed Plant | 5.31 | 5.32 | 0.00 | 2.31 | 63.15 |
| Other Non Pay | 3.25 | 3.22 | (0.04) | (1.20) | 39.69 |
| **Non-Pay Total** | **18.65** | **19.48** | **0.83** | **7.74** | **223.27** |
| | | | | | |
| **Grand Total** | **0.88** | **1.10** | **0.22** | **1.03** | **14.21** |

**Integration**

| I&E by Subjective Heading | Mth Bud £m | Month Act £m | Mth Var £m | YTD Var £m | Total Ann Bud £m |
|---|---|---|---|---|---|
| Income | (0.63) | (1.60) | (0.98) | (4.40) | (7.50) |
| Pay | 0.42 | 0.57 | 0.15 | (1.01) | 5.00 |
| Non-Pay | 0.21 | 1.03 | 0.83 | 5.40 | 2.50 |
| **Grand Total** | **0.00** | **(0.00)** | **(0.00)** | **0.00** | **0.00** |

Note: In this analysis adverse variances are shown as a positive number

## Income:

Total income YTD is 2.18% over the plan.

Private Patients had another relatively low month, generating £0.71m vs. a plan of £0.79m. Their income is now 6.5% above the plan, a reduction from last month. Winter Pressure funding makes up £0.85m of the YTD income.

## Pay:

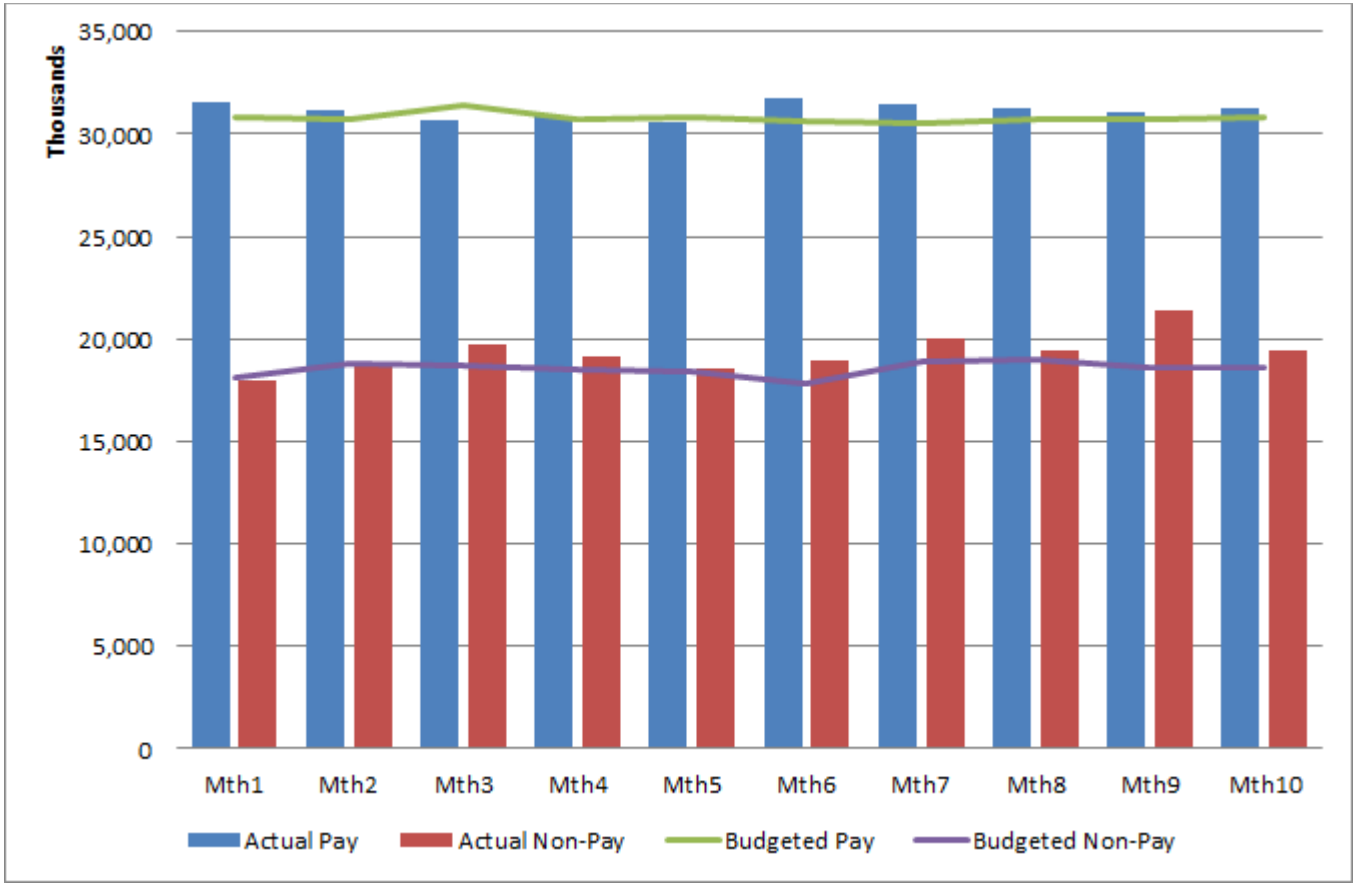
Pay for M10 is very similar to the previous month and has increased very slightly to 1.24% overspent YTD, whilst agency spend has once again made up 9.5% of the total pay bill.

## Non Pay:

Total Non pay is 4.17% over spent YTD.

Drug cost has reduced significantly from last month, to £4.7m, although this and other clinical supplies remain the main area of over spend.

# Expenditure Trend – Excluding Integration




**Pay:**

The graph shows the relatively consistent level of pay, although there is a modest increase, after three successive periods of reduction.

**Non-Pay:**

The graph for non-pay reiterates the reduction in drug costs in M10, after the large increase in M09. Other non-pay costs have also slightly reduced in M10, contributing to an overall drop of £1.9m.

# Income & Expenditure Month 10 – Directorate Analysis

| I&E by Directorate | Pay | | | Non Pay | | | TOTAL inc Income | | | Total Ann Bud £m | YTD Var |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | YTD Bud £m | YTD Act £m | YTD Var £m | YTD Bud £m | YTD Act £m | YTD Var £m | YTD Bud £m | YTD Act £m | YTD Var £m | | |
| **Directorate: Clinical** | | | | | | | | | | | |
| General Surgery & Urology | 20.7 | 20.7 | 0.0 | 4.8 | 4.7 | (0.1) | (0.8) | (0.7) | 0.1 | 29.6 | (0.02) |
| Medicine: Frimley | 39.5 | 41.3 | 1.7 | 21.2 | 25.3 | 4.1 | (0.6) | (0.7) | (0.1) | 72.2 | 5.76 |
| Medicine: Wexham | 45.1 | 46.1 | 0.9 | 20.0 | 22.1 | 2.2 | (0.9) | (0.9) | 0.0 | 77.3 | 3.12 |
| Orthopaedics & Plastics | 18.2 | 18.8 | 0.7 | 9.4 | 9.6 | 0.2 | (0.0) | (0.0) | 0.0 | 33.0 | 0.88 |
| Paeds, Maternity & Gynae | 38.8 | 39.0 | 0.2 | 4.9 | 5.0 | 0.0 | (0.7) | (0.4) | 0.3 | 51.6 | 0.57 |
| Pathology | 16.6 | 16.0 | (0.6) | 12.0 | 12.2 | 0.2 | (4.2) | (4.4) | (0.2) | 29.5 | (0.69) |
| Private Patients | 4.2 | 4.0 | (0.2) | 1.3 | 1.3 | 0.0 | (7.9) | (8.4) | (0.5) | (2.9) | (0.67) |
| Radiology | 11.1 | 12.0 | 1.0 | 7.1 | 7.7 | 0.5 | (0.3) | (0.3) | 0.0 | 21.5 | 1.50 |
| Specialist Surgery | 11.7 | 11.2 | (0.5) | 8.0 | 8.0 | (0.1) | (0.8) | (0.8) | 0.0 | 22.7 | (0.52) |
| Theatres, Crit Care & Anaes | 35.1 | 37.6 | 2.5 | 12.1 | 11.6 | (0.5) | (0.2) | (0.2) | 0.1 | 56.3 | 2.07 |
| **Clinical Total** | **240.9** | **246.7** | **5.7** | **100.8** | **107.4** | **6.6** | **(16.5)** | **(16.8)** | **(0.3)** | **390.7** | **11.99** |
| **Directorate: Corporate** | | | | | | | | | | | |
| Director of Integration | 4.2 | 3.2 | (1.0) | 2.1 | 7.5 | 5.4 | (6.3) | (10.6) | (4.4) | 0.0 | 0.00 |
| Finance & Strategy | 11.8 | 11.5 | (0.3) | 5.0 | 6.0 | 1.0 | (0.2) | (0.1) | 0.0 | 20.0 | 0.70 |
| HR & Corporate Services | 19.5 | 19.3 | (0.2) | 23.6 | 24.0 | 0.4 | (6.6) | (6.6) | (0.0) | 44.1 | 0.20 |
| Medical Director | 0.9 | 0.9 | (0.0) | 1.1 | 0.9 | (0.2) | (1.2) | (1.2) | (0.1) | 1.0 | (0.31) |
| Nursing & Quality | 4.1 | 3.9 | (0.2) | 1.8 | 1.8 | (0.0) | (1.1) | (1.0) | 0.1 | 5.8 | (0.15) |
| Operations: Frimley | 15.0 | 15.1 | 0.1 | 7.4 | 6.7 | (0.7) | (5.9) | (7.3) | (1.4) | 19.9 | (2.06) |
| Operations: Wexham | 13.4 | 12.8 | (0.5) | 1.2 | 2.6 | 1.4 | (0.3) | (0.3) | 0.0 | 17.1 | 0.95 |
| **Corporate Total** | **68.8** | **66.6** | **(2.2)** | **42.3** | **49.6** | **7.3** | **(21.4)** | **(27.2)** | **(5.8)** | **108.0** | **(0.67)** |
| | | | | | | | | | | | |
| **CCG Income and financing cost** | **2.4** | **1.7** | **(0.7)** | **44.7** | **43.9** | **(0.8)** | **(452.8)** | **(461.6)** | **(8.8)** | **(484.5)** | **(10.29)** |
| | | | | | | | | | | | |
| **Grand Total** | **312.2** | **315.0** | **2.8** | **187.8** | **200.9** | **13.1** | **(490.6)** | **(505.6)** | **(14.9)** | **14.2** | **1.03** |

The clinical areas are bearing the brunt of the financial pressure and consequent overspends, with the pay budgets in Medicine (FPH) and Theatres, Critical Care & Anaesthetics being under most pressure caused by both the level of activity and the cost of covering vacant posts.

The two Medical directorates, which have the largest value of drug expenditure and high cost devices, are also the areas most overspent and is closely linked to activity pressures.

Note: In this analysis adverse variances are shown as a positive number

## Total Trust Agency Expenditure (Excl. Winter Pressures (FPH) and Integration funded spend)

*Agency expenditure has reduced slightly from the previous month.*

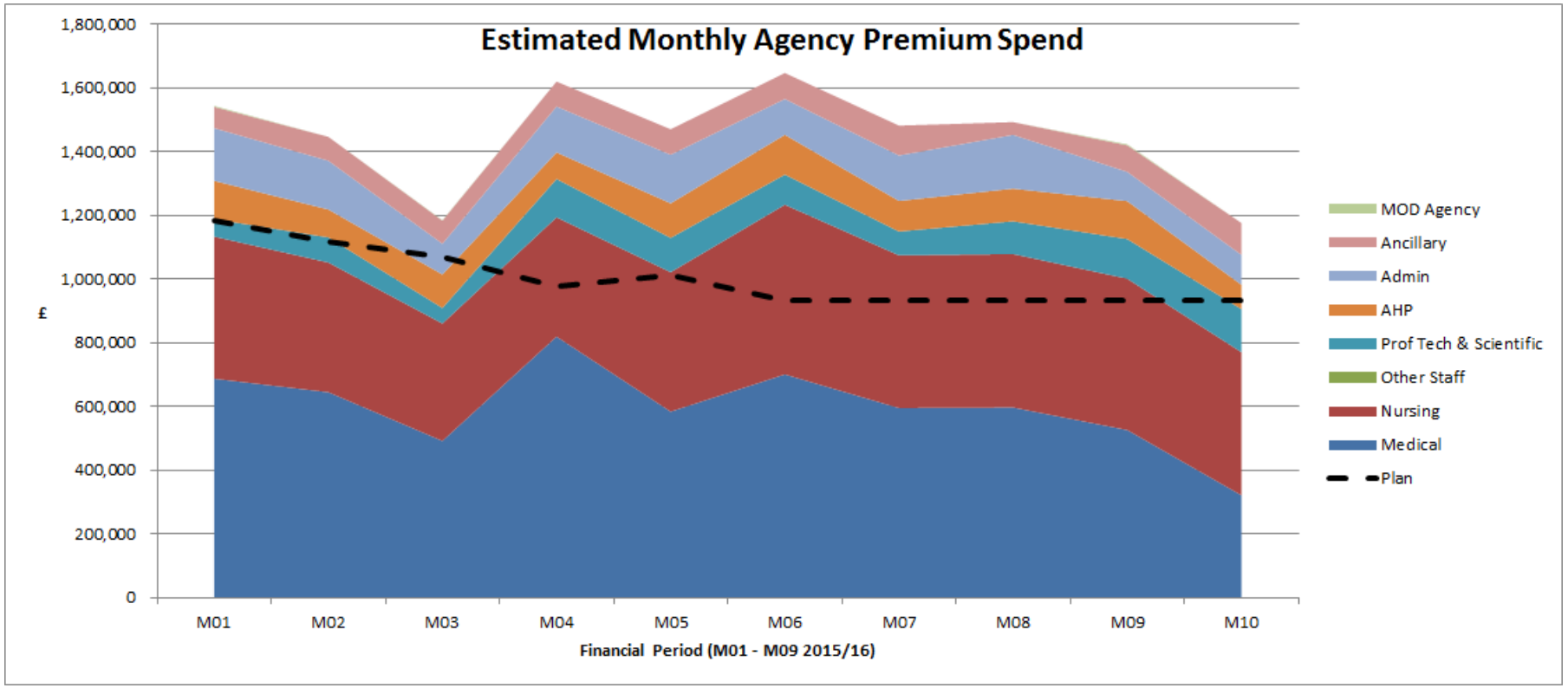
| | Hospital Agency | 2014/15 Average | M07 | M08 | M09 | M10 |
|---|---|---|---|---|---|---|
| FPH | Medical | 580,238 | 537,317 | 540,473 | 409,321 | 83,273 |
| | Nursing | 487,269 | 327,043 | 325,880 | 260,975 | 253,802 |
| | Prof Tech & Scientific | 0 | 66,526 | 140,569 | 79,390 | 102,283 |
| | AHP | 0 | 69,811 | 58,924 | 93,656 | 94,919 |
| | Admin | 0 | 112,963 | 25,368 | 74,474 | 9,000 |
| | Ancillary | 0 | 12,388 | 2,005 | 7,077 | 35,891 |
| | MOD Agency | 0 | 0 | 0 | 5,850 | 0 |
| | Other Staff | 180,070 | | | | |
| **FPH** | | **1,247,577** | **1,126,048** | **1,093,219** | **930,743** | **579,168** |
| WPH | Medical | 829,817 | 653,696 | 653,909 | 643,635 | 559,718 |
| | Nursing | 809,852 | 631,893 | 637,790 | 689,483 | 645,001 |
| | Prof Tech & Scientific | 0 | 83,011 | 65,138 | 169,383 | 167,775 |
| | AHP | 0 | 121,877 | 145,885 | 144,503 | 58,161 |
| | Admin | 0 | 172,903 | 312,137 | 109,144 | 178,769 |
| | Ancillary | 0 | 174,982 | 78,481 | 159,875 | 163,960 |
| | MOD Agency | 0 | 0 | 0 | 0 | 0 |
| | Other Staff | 551,104 | | | | |
| **WPH** | | **2,190,774** | **1,838,362** | **1,893,339** | **1,916,023** | **1,773,384** |
| | | | | | | |
| **Total** | | **3,438,351** | **2,964,410** | **2,986,558** | **2,846,766** | **2,352,553** |

Total agency spend is relatively unchanged from M09, however, in this report Winter Pressure and Integration funded agency costs are excluded. In this month a large value of agency medical costs were transferred to Winter Pressures, following a proper review of the projects and how they are coded. That being said, there has been an improvement in agency nursing costs across both sites.

Nurse agency spend for M10 was 9.85% of all nursing spend. Down from 10.54% in M09.

| YTD Cumulative | Mth1 | Mth2 | Mth3 | Mth4 | Mth5 | Mth6 | Mth7 | Mth8 | Mth9 | Mth10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nursing Spend | 9,420,249 | 18,701,218 | 27,846,970 | 36,905,210 | 45,995,792 | 55,415,139 | 64,692,576 | 74,005,493 | 83,279,403 | 92,669,247 |
| Nurse Agency Spend | 937,007 | 1,781,434 | 2,549,017 | 3,327,969 | 4,232,846 | 5,327,481 | 6,311,255 | 7,300,581 | 8,278,017 | 9,202,552 |
| % | 9.95% | 9.53% | 9.15% | 9.02% | 9.20% | 9.61% | 9.76% | 9.86% | 9.94% | 9.93% |

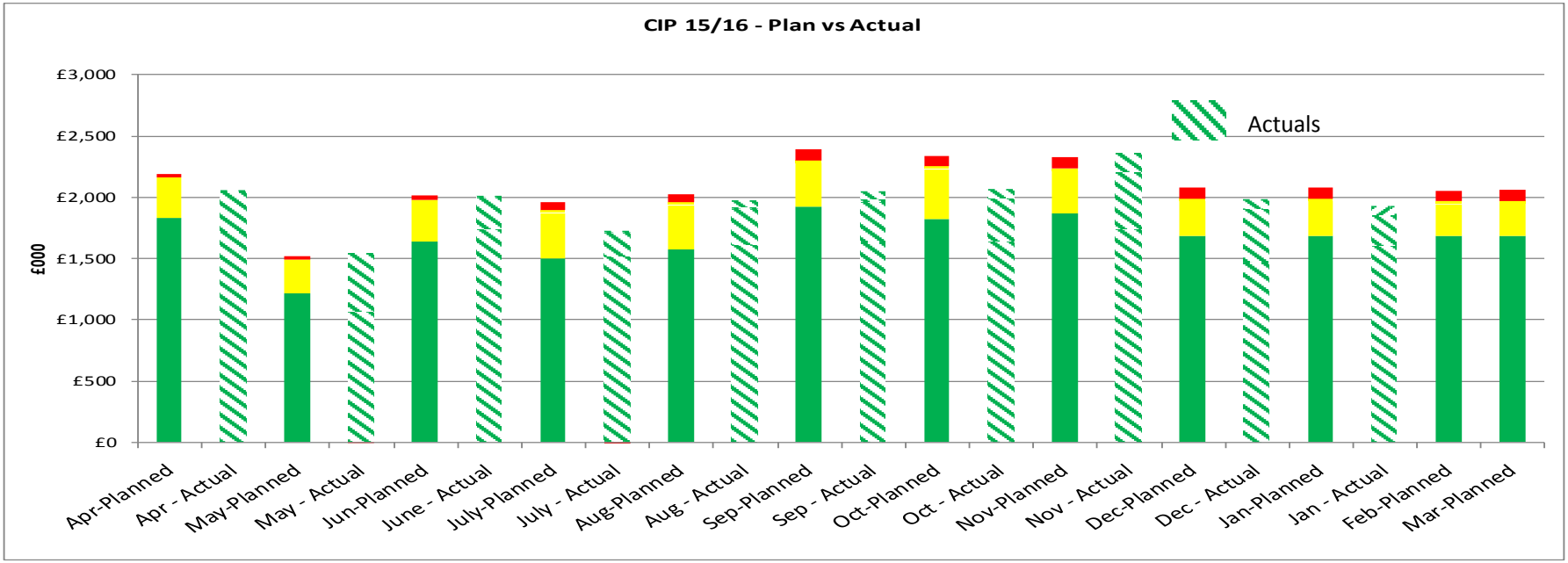
## Total Trust Agency Expenditure (Excl. Winter Pressures (FPH) and Integration funded spend) Premium Element Only




The dotted line shows the expected reduction in agency premium spend, this reduction was predicated on delivery of the CIPs. Actual expenditure has dropped significantly in M10 mainly due to the reallocation of medical staff agency to the Winter Pressures cost centre.

# Trust Overview – 2015/16 Total CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| £21.4m | £25m | £2.076m | £1.931m | -£0.145m | £20.912m | £19.664m | -£1.247m |



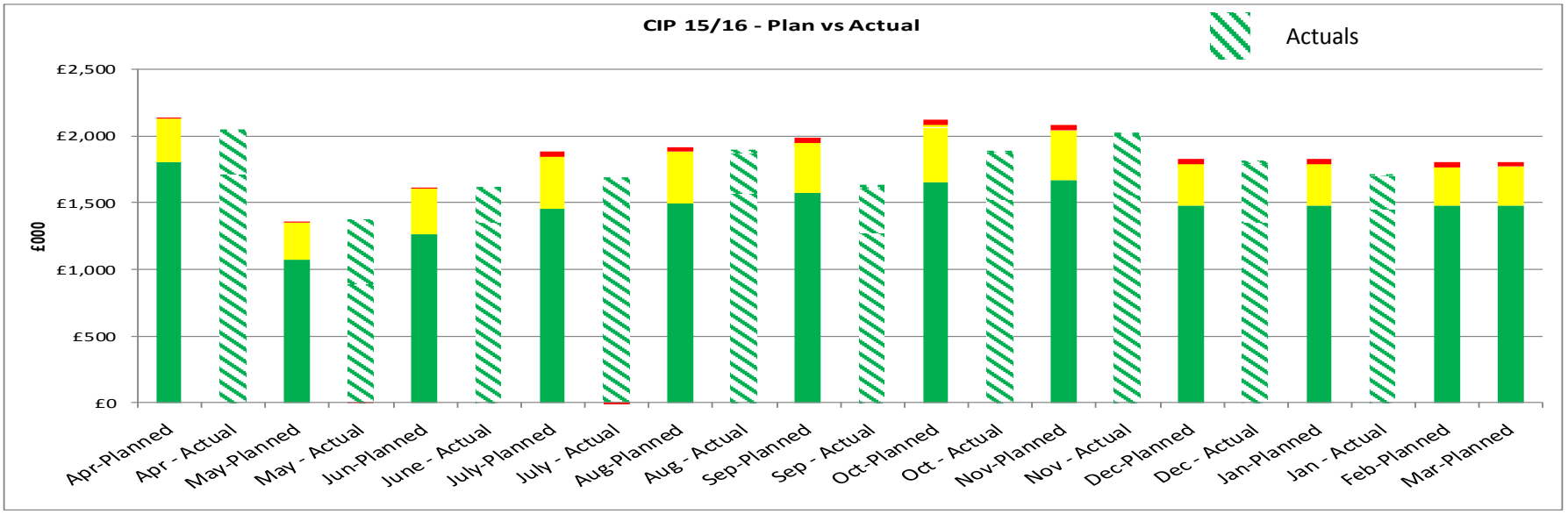

► At Month 10, the Trust has delivered **£1.931m** of cost improvement against the in- month plan of **£2.076m** – which represents a variance from plan of **-£145k** (or **-6.99%**)

► At Month 10, the year to date delivery against **£20.912m** total CIP schemes is **£19.664m** which represents a variance from plan of **-£1.247m**(or **-5.96%**)

All values in £000

# Trust Overview – 2015/16 Core CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| **£21.4m** | **£22.4m** | **£1.827m** | **£1.718m** | **-£0.109m** | **£18.781m** | **£17.694m** | **-£1.086m** |

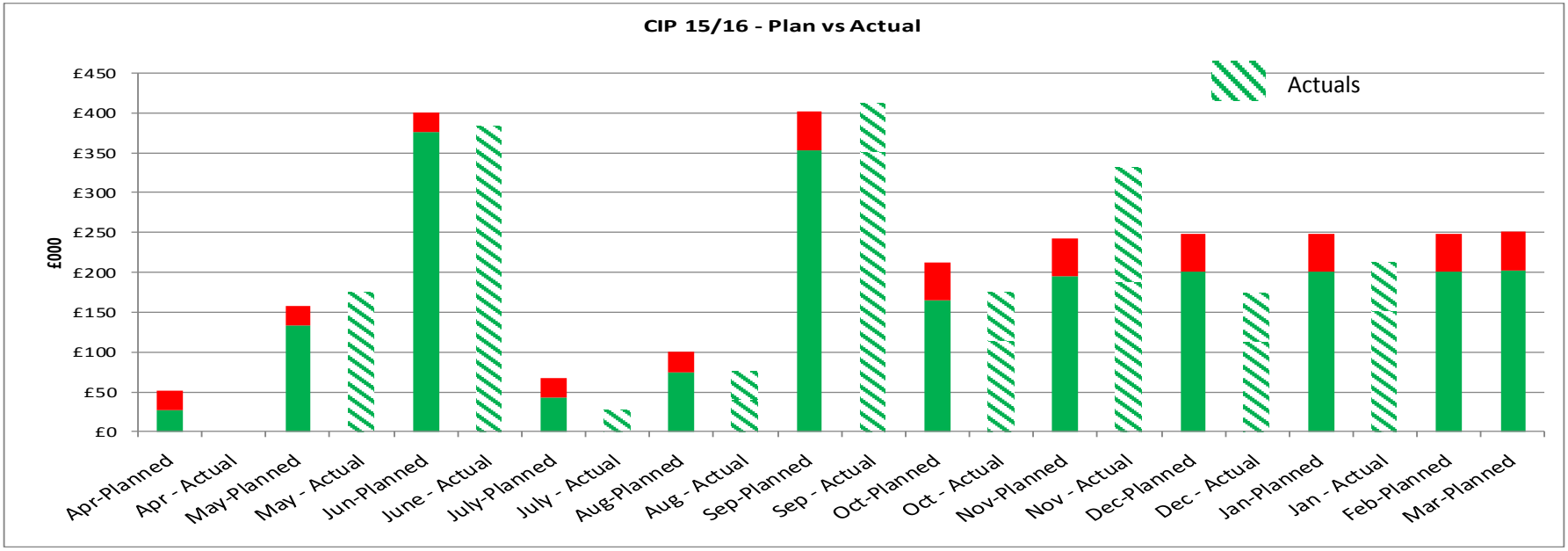



- At Month 10, the Trust has delivered **£1.718m** of cost improvement against the plan in month of **£1.827m**.
- At Month 10, delivery against plan is **-£109k for January.**
- At Month 10, the year to date CIP delivery against plan is **-£1.086m** (or **-5.78%**) against a year to date plan of **£18.781m**.

All values in £000

# Trust Overview – 2015/16 Additional CIP Schemes

| Target | Total CIP Value | M10 - Plan | M10 - Actual | M10 Variance | YTD - Plan | YTD - Actual | YTD Variance |
|---|---|---|---|---|---|---|---|
| £3.1m | £2.6m | £0.249m | £0.213m | -£0.036m | £2.131m | £1.970m | -£0.161m |




► At Month 10, delivery against plan is an under achievement of -£36k for January.

► At Month 10, the year to date delivery against **£2.6m** additional CIP schemes is **£1.970m** which represents a variance from plan of **-£161k** (or **-7.55%**)

All values in £000

## Capital Month 10

| £'m | Month Plan | Month Actual | Diff | YTD Plan | YTD Actual | Diff | FY Plan | FY Forecast | Diff |
|---|---|---|---|---|---|---|---|---|---|
| **HWPH** | | | | | | | | | |
| Heatherwood | 0.10 | 0.10 | (0.00) | 1.48 | 1.89 | (0.41) | 1.68 | 2.30 | (0.62) |
| Wexham - Emergency Dept | 0.25 | 0.01 | 0.24 | 0.80 | 0.40 | 0.40 | 1.00 | 0.60 | 0.40 |
| Wexham - Women's and Children's | 0.10 | (0.02) | 0.12 | 0.81 | 0.26 | 0.55 | 0.95 | 0.45 | 0.50 |
| Wexham - Estate | 1.14 | 0.70 | 0.44 | 10.30 | 4.69 | 5.61 | 11.91 | 6.95 | 4.96 |
| Information technology | 0.52 | 0.02 | 0.49 | 3.57 | 0.30 | 3.27 | 4.60 | 0.85 | 3.75 |
| Medical equipment | 0.33 | 0.12 | 0.21 | 2.41 | 0.63 | 1.78 | 3.08 | 2.30 | 0.78 |
| ***HWPH total*** | **2.44** | **0.94** | **1.50** | **19.37** | **8.17** | **11.20** | **23.22** | **13.45** | **9.77** |
| **FPH** | | | | | | | | | |
| Estate | 0.98 | 0.21 | 0.77 | 8.94 | 4.03 | 4.91 | 10.50 | 6.39 | 4.12 |
| Medical Equipment | 0.07 | 0.00 | 0.07 | 0.67 | 0.91 | (0.24) | 0.80 | 1.13 | (0.33) |
| Information Technology | 0.35 | 0.10 | 0.26 | 3.20 | 0.90 | 2.30 | 3.91 | 1.41 | 2.50 |
| ***FPH total*** | **1.40** | **0.31** | **1.10** | **12.81** | **5.84** | **6.98** | **15.21** | **8.93** | **6.29** |
| **Integration capital** | **0.32** | **0.01** | 0.31 | **2.13** | **0.20** | 1.93 | **2.77** | **1.10** | 1.67 |
| **Frimley Health Total** | **4.16** | **1.25** | **2.91** | **34.31** | **14.21** | **20.11** | **41.20** | **23.48** | **17.73** |

Month 10 saw an under spend against plan of £2.9m further increasing the YTD under spend to £20.1m and resulting in a further reduction in the full year forecast to £23.5m against an original forecast of £41.2m and a revised plan of £31.0m.

The FBC redevelopments and site specific Estates programme's fell a further £1.6m behind plan in month and are now £11.1m behind plan YTD as a result primarily due to the postponement of the 28 bed modular build new ward on the Wexham Park site, delays to implementation of the car park at Wexham Park, the postponement of refurbishment projects to summer 2016 at Frimley Park and the deferral of new office accommodation.

Medical equipment on the Wexham Park site is £1.8m behind plan YTD however £1m of the under spend is anticipated to be recovered by the end of the year as commitments of £1.5m have been made in the past month.

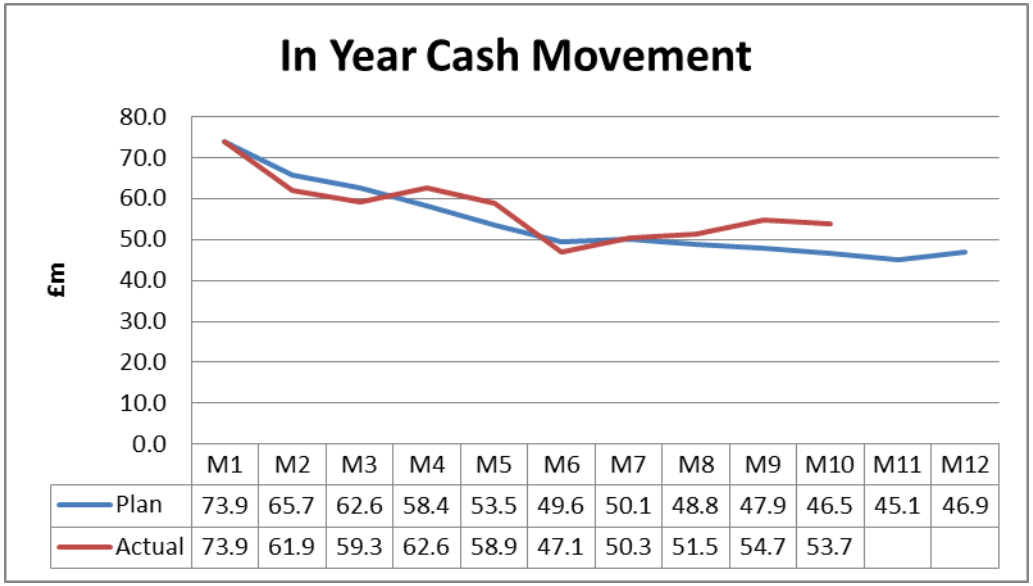
Progress on the IM&T and Integration programme's remains slow and these are now forecast to be £7.5m behind an original plan of £11.3m.

# Cash Position Month 10

| FRIMLEY HEALTH | Current Month Plan £m | Current Month Actual £m | Current Month Variance £m | Year to Date Plan £m | Year to Date Actual £m | Year to Date Variance £m | Full Year Forecast Plan £m | Full Year Forecast Forecast £m | Full Year Forecast Variance £m |
|---|---|---|---|---|---|---|---|---|---|
| **Net Cash Increase / (Decrease)** | -1.4 | -1.1 | **0.3** | -12.6 | -5.4 | **7.2** | -12.2 | 1.5 | **13.7** |
| Cash Brought Forward | 47.9 | 54.7 | **6.8** | 59.1 | 59.1 | **0.0** | 59.1 | 59.1 | **0.0** |
| **Cash Carried Forward** | **46.5** | **53.7** | **7.2** | **46.5** | **53.7** | **7.2** | **46.9** | **60.6** | **13.7** |

The cash balance was broadly in line with plan in month 10 having decreased by £1.1m which represents a favourable variance of £0.3m in month.

The year to date balance is ahead of plan by £7.2m at £53.7m due primarily to the strong working capital position and underspend against the capital programme and although it is anticipated that the working capital position will weaken as trade and other payables are recovered, as a result of the underspend on the internally funded Frimley Park capital programme and the additional revenue support funding being provided the forecast closing cash position for the year is now £60.6m against a plan of £46.9m.




| | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | 73.9 | 65.7 | 62.6 | 58.4 | 53.5 | 49.6 | 50.1 | 48.8 | 47.9 | 46.5 | 45.1 | 46.9 |
| Actual | 73.9 | 61.9 | 59.3 | 62.6 | 58.9 | 47.1 | 50.3 | 51.5 | 54.7 | 53.7 | | |

# Balance Sheet M10

| | Frimley Health | | | |
|---|---|---|---|---|
| | October Actual £m | November Actual £m | December Actual £m | January Actual £m |
| **Non-Current Assets** | **307.177** | **308.837** | **308.935** | **308.667** |
| **Current Assets** | | | | |
| Inventories | 3.511 | 3.137 | 3.287 | 3.216 |
| Trade and Other Receivables | 24.411 | 30.128 | 27.667 | 31.355 |
| Other Financial Assets | 16.843 | 13.162 | 14.389 | 10.433 |
| Prepayments | 9.797 | 10.432 | 9.309 | 8.668 |
| Cash | 50.300 | 51.494 | 54.733 | 53.665 |
| **Current Assets Total** | **104.862** | **108.353** | **109.385** | **107.337** |
| **Total Assets** | **412.039** | **417.190** | **418.320** | **416.004** |
| **Current Liabilities** | | | | |
| Loans | 0.000 | 0.000 | 0.000 | 0.000 |
| Deferred Income | (8.389) | (6.878) | (8.295) | (5.899) |
| Current Tax Payables | (6.682) | (6.650) | (6.558) | (6.694) |
| Trade and Other Payables | (50.652) | (58.056) | (60.476) | (60.660) |
| Other Financial Liabilities | (3.492) | (3.219) | (1.921) | (2.788) |
| **Current Liabilities Total** | **(69.215)** | **(74.803)** | **(77.250)** | **(76.041)** |
| **Net Current Assets (Liabilities)** | **35.647** | **33.550** | **32.135** | **31.296** |
| **Non-Current Liabilities** | | | | |
| Loans | 0.000 | 0.000 | 0.000 | 0.000 |
| Provisions | (0.472) | (0.494) | (0.475) | (0.475) |
| Other Financial Liabilities | (0.537) | (0.518) | (0.476) | (0.464) |
| Intercompany Transactions | 0.000 | 0.000 | 0.000 | 0.000 |
| **Total Non-Current Liabilities** | **(1.009)** | **(1.012)** | **(0.951)** | **(0.939)** |
| **Total Assets Employed** | **341.815** | **341.375** | **340.119** | **339.024** |
| **Taxpayers Equity** | | | | |
| Public dividend capital | 194.659 | 194.659 | 285.391 | 285.391 |
| Retained Earnings | 19.123 | 18.683 | (73.305) | (74.400) |
| Charitable Funds | 0.000 | 0.000 | 0.000 | 0.000 |
| Revaluation Reserve | 128.033 | 128.033 | 128.033 | 128.033 |
| **Total Taxpayers Equity** | **341.815** | **341.375** | **340.119** | **339.024** |

Key variances are highlighted below;

•The combined assets across all 3 sites total £416m.

•Capital expenditure are seen very little movement in month with further slippage to plan.

•Cash holding continues to equate to approx 50 % of the currents assets and is favourable to plan.

•The Trust has billed 90% of Q1 and Q2 CCG income in the North so should be paid in due course and reduce debtors going forward.

•Trade and Other Payables have continue to be high due to the teething problems with the new finance invoice approval mechanism. All approved creditors continue to be paid within 30 day payment terms for all sites.

Frimley Health NHS
NHS Foundation Trust

# Board

| | |
|---|---|
| Report Title | **2015/16 Forecast Capital Outturn Report** |
| Date of Meeting | 4th March 2016 |
| Agenda Number | |
| Report type | • Note |
| Prepared by | Stephen Holmes, Associate Director of Capital, Capital Projects |
| Executive Lead | Janet King, Director of HR & Corporate Services |
| Executive Summary | This report has been produced to advise Board of capital expenditure to date and the anticipated outturn at 31st March 2016.<br><br>The year to date plan for capital projects across all three sites in 2015/16 is £27.7million. The current forecast out turn for this year is £17.8 million, a shortfall of £9.9 million. The principal contributors to the forecast variance is the postponement of the 28 bed modular build new ward on the Wexham Park site (£4m), delays to implementation of the car park at Wexham Park (£1.3m) ,the postponement of refurbishment projects to summer 2016 (G6, F1, etc. (£2.6m)) at Frimley Park, and deferral of new offices (£1.0m). |
| Background | The attached spreadsheet shows the year to date plan, expenditure to date and forecast out turn for each project identified in the 2015/16 capital plan.<br><br>A brief narrative, including an explanation as to any variance in the forecast outturn is recorded in the comments column. Further explanation is given in respect of the larger capital projects below |
| Issues and Options | • Heatherwood Redevelopment<br>Following a favourable response from the Planning Authority, the design team have been investigating a site option for the new hospital in the woodland to the south of the main hospital site. Assessments of both capital and income and expenditure is underway, but is not yet concluded. Following a further review of the Schedule of Accommodation to be provided the estimated capital cost now stands at £70.4 million.<br><br>Although there have been delays to the FBC delivery programme, due principally to the complexities of defining the clinical brief for the new facility and consideration of the location options, in-year expenditure is forecast to slightly exceed budget (due to the advance purchase of a CT scanner).<br><br>• ED Wexham Park<br>Significant engagement with senior clinicians and operational leaders in ED, medicine and surgery to agree 1:200 drawings in respect of the ground floor of ED has taken place. CDIC agreed that design work to plan two additional floors above ED to |

accommodate medical and surgical assessment beds should also take place. Considerable discussions have been had to agree a layout for the two upper floors. Current proposals show 54 bed/patient spaces on the first floor and 50 beds on the second floor. The estimated cost of the ED with AMU and SAU beds above is £49.0 million.

The preferred location of the new ED means that there is no longer a need to relocate the existing Rehab facility. Fee expenditure is forecast, however, to be in line with the in-year budget. CDIC approval to continue with the development of the upper floors is being sought in February 2016.

- Maternity Wexham Park

Design work is progressing well with 1:50 drawings for the project signed off and the stage 3 architectural design effectively complete. CDIC approval to appoint Kier to develop the scheme to Guaranteed Maximum Price stage was sought on 24 Friday 2016. The estimated cost of the project is now £11.5 million and requires a contribution of £1.4m from backlog maintenance funding.

Although design work is progressing roughly to programme (approx. 4 weeks delay), the reduced scope of works required within the current Gynaecology function has resulted in a saving to the project and a reduction in in-year expenditure.

- Car Park – Wexham Park

Start on site was achieved on 7th December 2015, with work to create new parking between the main building and the pond dues to complete in March 2016. All construction is forecast to complete in August 2016. Because of the planning delays, in year expenditure of approximately £1.3m has been re-profiled into 2016/17

- New ward – Wexham Park

The new 28 bed ward planned for Wexham Park has been put on hold, following the conclusion of the options appraisal for the location of the new ED facility. The capital allocated to the new ward project is to be redirected towards providing additional beds above the proposed ED. Consequently, £3.95m of in year expenditure has been re-profiled into 2016/17

- Paediatric HDU – Wexham Park

The business case to provide HDU facilities within the Paediatrics Ward at Wexham Park was approved in September 2015. A start on site is anticipated in February 2016 with completion in the following autumn. Approximately £130k has been brought forward from 2016/17.

- Roofing – Wexham Park

Phase 2 of the roof replacement works at Wexham park is due to complete in March 2016, by when approximately 40% of the flat roofs will have been replaced. Proposals for phase 3 are currently being developed.

- MRI Building – Frimley Park

CDIC approval to commence design work for the construction of a new MRI facility with clinical accommodation above is to be sought in February 2016. £230k of in-year expenditure to be re-profiled into 2016/17.

- Ward F9 Refurbishment Works - Frimley Park

Works to upgrade the two outstanding 6 bed bays in F9 were put on hold due to bed pressures over the summer. Although it was hoped that works could commence in spring 2016, the project has now been postponed until 2017.

- A&E Minors – Frimley Park

Works currently in design but start on site delayed until spring 2016 to avoid winter pressures. £280k of in-year expenditure to be re-profiled into 2016/17.

- Medical records – Frimley Park

Two light industrial units on Albany Park (to the South of the hospital) have been fitted out to accommodate the transfer of medical records from the main hospital site. Works

| | |
|---|---|
| | completed in January 2016. Transfer of records is expected to take until April 2016.<br><br>• Car Park expansion – Frimley Park<br>The construction of an additional deck to the car park at Frimley Park successfully completed in November 2016.<br><br>• New Ward – Frimley Park<br>The business case for the provision of 24 additional beds at Frimley Park was approved in May 2015. Tenders for the conversion of G6 to form a new ward were returned in November 2015. Works are unable to start, however, until medical records have moved off site. Anticipated completion of G6 is now November 2016. £1.9m of in-year expenditure has been re-profiled into 2016/17.<br><br>• Office Block – Frimley Park<br>Different options for the provision of temporary and permanent offices, in part to house staff displaced by the G6 works, are currently being pursued. In year expenditure of £950k has been re-profiled into 2016/17.<br><br>• Ward F1 – Frimley Park<br>Works to expand the paediatric ward F1 are currently in design with a start on site planned in Spring 2016. £650k of in-year expenditure has been re-profiled into 2016/17.<br><br>• Roof Structural Remedial Works<br>Works to address the structural problems with the roof beams at Frimley park are on-going. |
| Recommendation | |
| Appendices | |

| | Project Title | RAG | | Expenditure ('000's) | | | Status | Comments | Expected Completion Date |
|---|---|---|---|---|---|---|---|---|---|
| | | Program | Budget | Plan | YTD Expenditure | Forecast Outturn | | | |
| Heatherwood | Heatherwood Rebuild | ▼ | ▲ | 1,000 | 268 | 800 | **feasibility** | Expenditure on Design & Surveys Only | 2018 |
| | Heatherwood Decant Project | ▼ | ▲ | 395 | 42 | 50 | **feasibility** | Decant strategy dependant on location of new build | Dec-16 |
| | Heatherwood Mobile Scanner | ▲ | ▲ | 35 | 32 | 35 | **Complete** | | |
| | Hwd Backlog Maintenance | ▲ | ▲ | 600 | 259 | 400 | **On site** | | Mar-16 |
| | Heatherwood CT Scanner | ▲ | ▼ | 0 | 1285 | 1,400 | **Complete** | CT Scanner funded from main scheme | Dec-15 |
| | Heatherwood Block 40 Development | ▲ | ▲ | 0 | 8 | 50 | **feasibility** | | |
| | | | **Total** | **2,030** | **1,894** | **2,735** | | | |

| | Project Title | RAG | | Expenditure ('000's) | | | Status | Comments | Expected Completion Date |
|---|---|---|---|---|---|---|---|---|---|
| | | Program | Budget | Plan | YTD Expenditure | Forecast Outturn | | | |
| ED Redevelopment | ED Main scheme | ▼ | ▼ | 500 | 376 | 950 | **In Design** | Expenditure on Design & Surveys Only | Aug-17 |
| | ED Relocate rehab | ▲ | ▲ | 500 | 0 | 0 | **feasibility** | No Longer Required | |
| | ED Minor Projects | ▲ | ▲ | 0 | 21 | 50 | **Complete** | Point of Care facilities provided | Oct-15 |
| | | | **Total** | **1,000** | **397** | **1,000** | | | |

| | Project Title | RAG | | Expenditure ('000's) | | | Status | Comments | Expected Completion Date |
|---|---|---|---|---|---|---|---|---|---|
| | | Program | Budget | Plan | YTD Expenditure | Forecast Outturn | | | |
| Womens & Childrens | W&C Main Scheme | ▲ | ▼ | 500 | 236 | 590 | **In Design** | Expenditure on Design & Surveys Only | Aug-17 |
| | Maternity Works (Emergency Gynae) | ▲ | ▲ | 445 | 28 | 30 | **Complete** | Enabling work less than orignally anticipated | Oct-15 |
| | | | **Total** | **945** | **264** | **620** | | | |

| | Project Title | RAG | | Expenditure ('000's) | | | Status | Comments | Expected Completion Date |
|---|---|---|---|---|---|---|---|---|---|
| | | Program | Budget | Plan | YTD Expenditure | Forecast Outturn | | | |
| | 1) Cath Lab (12 recovery beds) c/fwds | ▲ | ▲ | 428 | 299 | 350 | **complete** | F/A agreed. | May-15 |
| | 1)Med Equip - Cardiac Catheter Lab | ▲ | ▲ | 590 | 590 | 590 | | F/A agreed. | May-15 |
| | 1) Theatre admissions lounge (and minor ops room) c/fwds | ▲ | ▲ | 422 | 289 | 422 | **on site** | Minor ops room and step down complete. Works to DSU on hold. | Mar-16 |
| | 1) Steam boiler controls upgrade | ▼ | ▼ | 40 | 49 | 110 | **on site** | delayed due to change in insurers | Feb-16 |
| | 1) Pre-assessment relocation | ▲ | ▲ | 200 | 0 | 75 | **on site** | SALT moving to Orange corridor. Minor works in plastics corridor to complete in March, then pre-assessment relocate. | Mar-16 |
| | 1) IM&T move (enabling work for Chemo | ▼ | ▲ | 50 | 0 | 50 | **in design** | IM&T to move to pre-assessment once vacated | Mar-16 |
| | 1) Eden Ward (Chemo expansion) | ▼ | ▲ | 350 | 0 | 50 | **Tender** | to commence once IM&T vacate - see above | Jun-16 |

Wexham Estate

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1) Car parking | ▼ | ▲ | 2,300 | 462 | 1,000 | **on site** | Area 3 being constructed | Jul-16 |
| 1) overflow car park | ▼ | ▲ | 175 | 0 | 100 | **on site** | Entrance to be completed Jan 16. surface to be installed. | Feb-17 |
| 1) Corridors (6 facet survey) | ▲ | ▲ | 150 | 47 | 100 | **tender** | corridors painted. Lighting being negotiated with EDF | Mar-16 |
| 1) Paediatric HDU | ▲ | ▲ | 0 | 25 | 130 | **tender** | To start Feb 2016 | Sep-16 |
| 1) Cardiology Simulation Facility (Legacy funded) | ▲ | ▲ | 180 | 6 | 6 | **on hold** | Cardiology to confirm requirement. | Mar-16 |
| 1) Ward Refurbishment (£400k per ward + backlog + | ▼ | ▲ | 61 | 0 | 10 | **on hold** | Need to identify 1st ward to be refurbished. | Mar-16 |
| 1) Wayfinding | ▲ | ▲ | 150 | 54 | 150 | **complete** | Further works requested | Oct-15 |
| 1) Project Feasibilites | ▲ | ▲ | 50 | 0 | 0 | | | |
| 1) New Ward (£570k legacy funded) | ▼ | ▲ | 4,070 | 36 | 40 | **on hold** | CCU step down on hold. Funds re-allocated to ED | Aug-17 |
| 1) Pharmacy consultation room | ▲ | ▲ | 100 | 2 | 100 | **on site** | works being phased. | Feb-16 |
| 1) Dental X-ray | ▲ | ▲ | 50 | 0 | 50 | **on site** | RDA to confirm ready for occupation | Feb-16 |
| 1) Pinewood Car Park | ▲ | ▲ | 0 | 0 | 50 | **feasibility** | Planning consultant appointed to achieve permanent permission | |
| 2) Compliance/ 6 Facet Survey Items | ▲ | ▲ | 0 | | | | | |
| 2) Structure | ▲ | ▲ | 69 | 0 | 10 | **feasibility** | structural surveys of Tower and Cath Lab underway | Mar-16 |
| 2) External Fabric | ▲ | ▲ | 121 | 44 | 121 | | Priorities being identified. Immediate issues being addressed. | Mar-16 |
| 2) Roof | ▲ | ▲ | 1,157 | 920 | 1,157 | **on site** | works continuing until February | Feb-16 |
| 2) Boiler plant and controls | ▲ | ▲ | 71 | 37 | 71 | **on site** | boiler controls being upgraded | Feb-16 |
| 2) Heating systems | ▲ | ▲ | 128 | 47 | 75 | **complete** | Temporary heating provided to tower | Nov-15 |
| 2) Hot and Cold Water Systems | ▲ | ▲ | 70 | 61 | 70 | **feasibility** | Drainage surveys underway. Strategy outstanding. | Nov-15 |
| 2) Ventilation Systems | ▲ | ▲ | 250 | 179 | 250 | **complete** | R22 units being replaced. | Aug-15 |
| 2) Lifts and Hoists | ▲ | ▲ | 118 | 0 | 10 | **feasibility** | Reports to be reviewed and recommendations actioned | Dec-15 |
| 2) Fixed Plant and Equipment | ▲ | ▲ | 61 | 0 | 10 | | Survey to be commissioned via EPC | |
| 2) Electrical Systems | ▲ | ▲ | 236 | 49 | 100 | **on site** | Work identified in 5 yearly testing being actioned | Dec-15 |
| 2) Communication Systems | ▲ | ▲ | 65 | 0 | 30 | **design** | Issues with nurse call bells being addressed. | Mar-16 |
| 2) Internal Fabric and Fixtures | ▲ | ▲ | 144 | 11 | 30 | | | |
| 2) Medical gas | ▲ | ▲ | 130 | 0 | 30 | **feasibility** | K&H review completed. £250k estimate to improve | Mar-16 |
| 2) Alarms and detection Systems | ▲ | ▼ | 119 | 150 | 160 | **tender** | Tenders for survey and schedule of rates to replace | Dec-15 |
| 2) Miscellaneous | ▲ | ▲ | 10 | 0 | 10 | | | |
| 3) Patient Environment | ▲ | ▲ | 0 | | | | | |
| 3) Statutory compliance - from condition | ▲ | ▲ | 1,000 | 588 | 718 | **feasibility** | Fire Compartmentation survey complete. Works to be | Mar-16 |
| 3) Toilets (6 facet survey) | ▲ | ▲ | 100 | 88 | 100 | **complete** | 2nd phase being planned | Nov-15 |
| 3) Pathology flammable store | ▲ | ▲ | 50 | 0 | 30 | **on site** | works start 25th Jan | Feb-16 |
| 4) Other | ▲ | ▲ | 0 | | | | | |
| 4) misc | ▲ | ▼ | 0 | 664 | 700 | | Prior year projects | |
| | | **Total** | **13,264** | **4,697** | **7,065** | | | |

| Project Title | RAG | | Expenditure ('000's) | | | Status | Comments | Expected Completion Date |
|---|---|---|---|---|---|---|---|---|
| | Program | Budget | Plan | YTD Expenditure | Forecast Outturn | | | |
| MRI Building | ▼ | ▲ | 250 | 3 | 20 | **feasibility design** | Revised feasability to be commissioned. | Dec-17 |
| Parkside Refurbishment | ▲ | ▲ | 250 | 55 | 200 | **design** | Windows - Mobilisation: Due to commence 8th Feb, complete 4th Mar. | Oct-15 |
| Ward F9 Refurbishment | ▼ | ▲ | 100 | 39 | 40 | **Price review** | Proposal to undertake works in summer 2016. Contractor reviewing price and programme for CDIC approval to proceed. | Oct-16 |
| A&E Minors Suite | ▼ | ▲ | 300 | 0 | 20 | **design** | In design. Start delayed to spring 2016 | Nov-16 |
| Medical Records | ▲ | ▲ | 1,100 | 548 | 1,100 | **on site** | Snagging and commissioning | Jan-16 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Frimley Estate | Car Park expansion | ▲ | ▲ | 2,500 | 2,002 | 2,500 | **Comp.** | Completed | Oct-15 |
| | New Ward (G6 Refurbishment) | ▼ | ▼ | 2,000 | 114 | 120 | **Mobilisation** | Tenders back. Start delayed pending clearance of medical records building | Oct-16 |
| | Office Block | ▲ | ▲ | 1,000 | 21 | 50 | **feasibility design** | On hold. | Dec-15 |
| | Ward F1 Teenage/Assessment Unit | ▼ | ▲ | 750 | 11 | 100 | **design** | Floor plans agreed by users. PTE under review. | Oct-16 |
| | Essential Maintenance (Property Maintenance) / Backlog | ▲ | ▲ | 750 | 407 | 750 | **on going** | Works in progress. | Mar-16 |
| | Roof/Structural Works (Property maintenance) | ▲ | ▲ | 1,000 | 581 | 1,000 | **on going** | Works to theatres 1-6 due to commence 18th Feb 16. | Mar-16 |
| | General Contingency/New Projects/Projects b/fwd | ▲ | ▲ | 500 | 250 | 485 | **on going** | Carry forwards 14/15 projects | Mar-16 |
| | | | **Total** | **10,500** | **4,031** | **6,385** | | | |

| | Plan | YTD Expenditure | Forecast Outturn |
|---|---|---|---|
| **TOTAL** | **27,739** | **11,283** | **17,805** |

Frimley Health NHS
NHS Foundation Trust

# TRUST BOARD

| | |
|---|---|
| Report Title | **Security Service – Heatherwood and Wexham Park Hospitals** |
| Date of Meeting | **4th March 2016** |
| Agenda Number | |
| Report type | For approval |
| Prepared by | Colin Simpson<br>General Manager Facilities<br>Kris Obariase<br>Programme Director HR & Non Clinical |
| Executive Lead | Janet King, Director of HR & Corporate Services |
| Executive Summary | Security at Wexham Park and Heatherwood Hospitals is currently provided via a contract with CP Plus ending late April 2016.<br><br>The aim is to take the contract back in-house with the view to manage the Heatherwood provision via Frimley Park Hospital |
| Background | Security and Car Parking is currently managed by CP Plus at a cost of £1.2m.p.a |
| Issues and Options | <u>Heatherwood and Wexham Park</u><br>Option 1 – Continue service as is<br><br>Option 2 – Bring full service in house |
| Recommendation | The Trust Board are asked to approve taking back in house the security services at Wexham & Heatherwood hospitals as described in option 2. |
| Appendices | Finance figures to bring service in-house. |

**SECURITY REVIEW and OPTIONS**

There are two options to consider.

**Option 1**

Continue Current Service by tendering the service. This option would not meet the strategy of the trust to provide a consistent approach to security across the three sites with Frimley currently in-house. No guarantee of savings to meet next year's CIP target of £200K

**Option 2**

Bring the service in house by May 1st 2016, managing Heatherwood hospital via Frimley Park. Easier to manage and support from the Frimley site than Wexham as geographically closer.

This would involve the following steps;

- Transfer all CP Plus staff via TUPE to the Trust.
- Transfer Heatherwood CCTV provision to Frimley Park at an estimated cost of £3000.
- Move the current security control office at Wexham Park hospital to Main Reception in order to provide the new service efficiently and in line with the proposed shift rota at an estimated cost of £45000
- Manage car parking in-house using warning notices. Loss of revenue from PCN's circa £2700 pa
- Purchase of new radio communication devices (currently use 15 year old handsets which are unreliable) £6000

Total estimated set-up cost of £54000. Estimated savings are a minimum £200K next financial year.

**Preferred Option**

The preferred option is option 2 bring service in house and realise £200K CIP saving in year 16/17. This will provide a consistent approach to Security across the Trust on all 3 sites. Enabling training and management of the staff to reflect the values of the Trust and deliver a much improved service to staff, visitors and patients.

**Appendix 1**

**In-Sourcing Security Team Budget Proposal 16/17**

| Wexham Park | | | | |
|---|---|---|---|---|
| Latest Option (Midpoint on scale) | | Band 2 | A/L Cover etc - 18% | Total Required Budget for 16/17 |
| Gross Cost | 19.00 | 385,463 | 53,965 | 439,428 |
| Enhancement Cost | | 40,451 | | 40,451 |
| Total | 19.00 | 425,914 | 53,965 | 479,879 |

| Heatherwood | | | | |
|---|---|---|---|---|
| Latest Option (Top of Scale) | | Band 2 | A/L Cover etc - 18% | Total Required Budget for 16/17 |
| Gross Cost | 10.00 | 226,530 | 40,775 | 267,306 |
| Enhancement Cost | | 21,353 | | 21,353 |
| Total | 10.00 | 247,883 | 40,775 | 288,659 |

| | | | | |
|---|---|---|---|---|
| TOTAL PAY | 29.00 | 673,797 | 94,740 | 768,537 |
| NON PAY | | | | 82,000 |
| CAR PARK SECURITY BUDGET 16/17 | | | | 850,537 |
| FORECAST OUTTURN 15/16 | | | | 1,050,537 |
| CIP DELIVERY 16/17 | | | | 200,000 |

Frimley Health NHS
NHS Foundation Trust

| | |
|---|---|
| Report Title | **Corporate Risk Assurance Framework – February 2016** |
| Agenda Number | 18. |
| Report type | To present Frimley Health NHS Foundation Trust's high level risks to the Board of Directors |
| Prepared by | Debbie Barrow<br>Governance Manager - Nursing & Quality |
| Executive Lead | Sir Andrew Morris<br>Chief Executive |
| Executive Summary | The Frimley Health Risk Assurance Framework (RAF) is the primary mechanism for high level risk management within the organisation.<br><br>This report summarises the discussions regarding 'high level' risks facing Frimley Health NHS Foundation Trust at the February 2016 meeting of the Corporate Governance Group. The method of scoring risks to categorise them as high, moderate and low risks is based on a '5 x 5' matrix. The risk rating is reached by scoring impact/consequence and likelihood on a scale of 1-5 and multiplying these together. |
| Issues and Options | In this version of the RAF, there are 7 'high' graded and 2 'extremely high' graded risks identified and these are summarised in the attached paper. 1 new risk was identified in relation to Asbestos at Heatherwood Hospital and three were re-graded. |
| Recommendation | The Board of Directors is asked to note the high level risks included in the Trustwide Risk Assurance Framework |
| Appendices | Corporate Risk Assurance Framework |

# Risk Assurance Framework - Risk Scoring Guide

Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on a Impact/Consequence x Likelihood matrix.

**Impact/Consequence-** The descriptors below are used to score the impact/ consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

| Level | Descriptor | Risk Type | | | |
|---|---|---|---|---|---|
| | | Injury/Harm | Service Delivery | Financial | Reputation/Publicity |
| 1 | Negligible | No injuries or injury requiring no treatment or intervention | Service Disruption that does not affect patient care | Less than £10,000 | Rumours |
| 2 | Minor | Minor injury or illness requiring minor intervention.<br>< 3 days off work if staff | Short disruption to services affecting patient care or intermittent breach of key target | Loss of between £10,000 and £100,000 | Local media coverage |
| 3 | Moderate | Moderate injury requiring professional intervention<br>RIDDOR reportable incident | Sustained period of disruption to services/sustained breach of key target | Loss of between £101,000 and £500,000 | Local media coverage with reduction in public confidence |
| 4 | Major | Major injury leading to long term incapacity requiring significant increased length of stay. | Intermittent failures in a critical service<br>Significant underperformance of a range of key targets | Loss of between £501,000 and £5M | National media coverage and increased level of political/public scrutiny<br>Total loss of public confidence |
| 5 | Extreme | Incident leading to death<br>Serious incident involving a large number of patients | Permanent closure/loss of a service | Loss of >£5M | Long term or repeated adverse national publicity<br>Removal of Chair/CEO or exec team |

**Likelihood-** The descriptors below are used to calculate the likelihood of the risk occurring.

| Level | Descriptor | Range |
|---|---|---|
| 5 | Almost Certain | More than 90% |
| 4 | Likely | 31% to 90% |
| 3 | Possible | 11% to 30% |
| 2 | Unlikely | 3% to 10% |
| 1 | Rare | Less than 3% |

## High Risk Summary

| Chart Ref | Risk Name | Source | Current Score | | | Target Score | Score Trend | | | | Date Risk Added | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | C | L | R | | Previous Month | 3 months ago | 6 months ago | Direction of Travel | | |
| **Corporate Objective 1: Pursuing the highest level of quality, patient experience and clinical outcomes** | | | | | | | | | | | | |
| A | Nurse Staffing Capacity | FPH/WPH | 4 | 4 | 16 | 8 | | | | ⇔ | Nov-12 | |
| B | Industrial Action by Junior Doctors | FPH/HWPH | 4 | 4 | 16 | 4 | | | | ⇑ | Nov-15 | |
| C | Infection Control (CDiff) | FPH/HWPH | 4 | 4 | 16 | 4 | | | | ⇔ | Aug-15 | |
| D | Estate & Infrastructure | HWPH | 4 | 4 | 16 | 4 | | | | ⇔ | Aug-14 | |
| E | Winter Bed Capacity | FPH/WPH | 4 | 4 | 16 | 4 | | | | ⇑ | Jul-15 | |
| F | A&E 4-hour Target | FPH/WPH | 5 | 4 | 20 | 8 | | | | ⇑ | Sep-12 | |
| **Corporate Objective 2: Transforming our infrastructure** | | | | | | | | | | | | |
| G | Delivery of Informatics Strategy 2015/16 | HWPH | 4 | 4 | 16 | 4 | | | | ⇑ | Apr-13 | |
| **Corporate Objective 3: Developing our Staff and our Culture** | | | | | | | | | | | | |
| H | Participation in Mandatory Training & Appraisals | HWP/FPH | 4 | 4 | 16 | 4 | | | | ⇑ | Jan-12 | |
| **Corporate Objective 4: Breaking through traditional healthcare boundaries** | | | | | | | | | | | | |
| **Corporate Objective 5: Developing leading edge services** | | | | | | | | | | | | |
| **Corporate Objective 6: Keeping Control of Resources** | | | | | | | | | | | | |
| I | Failure to achieve Medium Term Financial Sustainability | FH | 4 | 5 | 20 | 4 | | | | ⇔ | Sep-11 | |

## High Risk Tracking Matrix

| Likelihood | Consequence | | | | |
|---|---|---|---|---|---|
| | Insignificant | Minor | Moderate | Major | Catastrophic |
| Rare | | | | | |
| Unlikely | | | | | |
| Possible | | | | | |
| Likely | | | | A C B D E G | |
| Almost Certain | | | | I | F |

| Risk Name | Current Risk Rating | Actions | Assurance |
|---|---|---|---|
| Failure to achieve medium term financial sustainability (FPH/HWPH) | **20** | • FBC actions to be reassessed (increases in private and elective activity). Additional savings programmes to be developed. Consideration to be given to which services should be located on which sites.<br>• Medium term savings opportunities being reviewed with Ernst & Young, presented to BOD at Away Day<br>• Benchmarking being undertaken to highlight areas to target savings<br>• Major workstreams across Trust established | • Plans to be approved & reviewed at Board level<br>• External assurance may be sought |
| A&E 4-Hour Target<br>Risk to Monitor governance rating due to failure to deliver A&E 4 hour target and pressures on bed capacity and patient flow with potential to impact ability to deliver routine and critical services, delay in patient treatment, quality of care, and patient safety. | **20** | • The enlarged Trust has delivered Q1 and Q2 2015/16 position but, entering the winter period, the target remains at risk in respect of both A&E Departments.<br>• Increase nursing and medical staffing, particularly out of hours.<br>• Winter pressures wash up meeting to be held.<br>• Changing shift patterns to meet peaks in demand.<br>• Remedial action plan regarding patient flow and discharge<br>• BOD approval for wards to support bed capacity challenges<br>• Winter pressures money being discussed with CCGs<br>• Q1 achieved for Frimley Health<br>• 7 day consultant provision across all specialties. To Review 7 day provision in line with national requirements<br>• Increase the number of pathways applicable to AECU<br>• 22 beds opened Bourne Ward, Farnham in November 15 and a further 22 beds opened on Hale Ward January 16<br>• WPH SRG to streamline out of hospital care<br>• To benchmark Trust position against other Trusts<br>• Further beds to be open at Farnham.<br>• Work needed with social care on delays<br>• Frimley Health - 25th out of 136 Trusts even though at 92% | • Weekly performance meetings.<br>• Daily monitoring of breaches of A&E 4 hour target.<br>• Daily alerts to CEO.<br>• Performance on standard reported directly to the Board.<br>• Reviewed by Hospital Executive Board and Quality Assurance Committee on behalf of the Board. |
| Risk of failure to deliver the Informatics Strategy 15/16 as a key part of the @transforming our Infractruture' objective (FPH.HWPH) | **16** | • Re-establish Informatics Steering Board<br>• Identify clinical leads for each project and engage external support<br>• Individual schemes being reviewed to line up with integrated Trustwide strategy<br>• Combined Strategy for 2015/16 to Board April 2015<br>• IT Departments currently being restructured to provide one service cross all 3 sites<br>• Interviews arranged for Head of IT post | • Reviewed by Informatics Board with key outcomes reported to the Board via the Hospital Executive Board |
| Potential risk to patient care due to nursing staff capacity (FPH &HWPH) | **16** | • Establishment review to be undertaken against agreed standards<br>• Recruitment drive to Philippines, 129 posts offered, currently at next stage of recruitment<br>• Improved education and support for newly qualified & student nurses through Preceptorship Programme<br>• Multiple retention schemes being explored at corporate and local level | • Recruitment progress reviewed at Weekly Ward Moves meeting, chaired by Deputy COO<br>• Board will receive assurance via the Quality Assurance Committee<br>• Workforce Group established which monitors management |

| | | | |
|---|---|---|---|
| | | • Successful recruitment of student nurses, 40 places offered on Wexham site<br>• Ward staffing model being reviewed on H&W sites<br>• Temporary staffing workstreams<br>• Increase demand for nursing capacity to facilitate staffing of 2 new wards, currently 150 WTE vacancies<br>• Further European recruitment and RR action plan in place - 70 nurses being interviews in October<br>• Enhanced preceptorship<br>• Improved student nurse support<br>• Band 4 development<br>• Specialist nurses offering support to wards areas and practice development team undertaking clinical shifts.<br>• Matrons working clinically in ward areas at time of short staffing | of risk, reporting into Hospital Executive Board |
| Participation in Mandatory Training & Appraisals | **16** | • E-learning packages continue to be rolled out and technical issues being addressed.<br>• Alternative delivery methods to be employed, e.g. hosting training in workplace where possible.<br>• Development of single metric for inclusion on Trust and divisional balanced scorecards.<br>• Learning from other NHS bodies to be accredited to avoid duplication for new staff.<br>• Data cleansing work with support from IM&T.<br>• FPH paper to go to Quality Committee with recommendations around mandatory training.<br>• Mandatory training requirements agreed for doctors<br>• Problem with WIRED, no training reports available for either site until end April 15 – risk escalated due to lack of assurance regarding availability of training reports<br>• New Policy to be launched | • Board will be updated via the Trust Corporate Governance Group<br>• Workforce Group established which monitors management of risk, reporting into Hospital Executive Board |
| Potential risk as a result of inconsistencies and pockets of poor infection control practice (WPH) | **16** | • Review of antibiotic formulary and prescribing compliance<br>• Reinforce best practice in hand hygiene and infection control<br>• Undertake full RCA of incidence of infection including CDiff and act upon the findings<br>• Clinical teams to present findings of RCAs at BOD<br>• Review membership and strengthen attendance at the Hospital Infection Control Committee (HICC) | • Board Monthly Performance Report |
| Estate & Infrastructure<br>Potential risk to patient safety with action required to address immediate estate priorities. Ensure the estate is fit for purpose & that leaks, repairs & maintenance is planned & dealt with in a timely manner (HWPH) | **16** | • Full condition survey commissioned, report received, findings and priorities presented to Capital Planning meeting February/March 2015<br>• HWP implementing a new maintenance scheduling system 'Planet'<br>• Decommissioning plan for Heatherwood, currently under review in light of opening old Ward 4 for Ortho and future use of the Mental Health buildings<br>• Programme of work in place to address issues highlighted in each of 3 areas in OPD (Plaster Room, Prosthetic Room, Decontamination Room) | • Programme of works monitored by Capital Planning Committee |

| | | | |
|---|---|---|---|
| Winter Bed Capacity<br>Risk to patient experience due to potential for lack of sufficient bed capacity to meet demand during Winter months 15/16 | **16** | • New 22 bedded ward on FPH site by end of Q4 15/16<br>• New 22 bedded ward on Wexham site agreed by Board; however currently under review to assess possibility of incorporating in new ED build.<br>• Discussions with Hants/Bracknell Social Services to assist with providing care packages<br>• Business case to identify feasibility/cost of additional beds as Farnham Hospital<br>• Work with NE Hans on Vanguard scheme to provide integrated care hubs to reduce admissions to FPH<br>• Additional beds available at Farnham Hospital<br>• To review possibility of transferring patients awaiting discharge to different care settings that are more cost effective<br>• 2 x 21-bedded ward open at Farnham Hospital (Bourne & Hale Wards)<br>• Scheduling new ward at FPH (G6) | • 6-monthly updates presented to BOD |
| Industrial Action by Junior Doctors<br>Potential risk to patient safety due to lack of junior doctors available during industrial action | **16** | • Increased consultant cover on the wards<br>• Increased nursing cover on wards including practice development and specialist nurses<br>• Some elective surgery cancelled<br>• Industrial action deferred until the New Year, decision to be made 13/1/16<br>• Industrial action planned for 12/01/16, 26/01/16 & 10/02/16. Approx cost of industrial action 1.5 million per day ( cancelation of elective surgery) | • Monitored by Top Team |

Frimley Health NHS
NHS Foundation Trust

**Board of Directors**
**Friday 4th March 2016**

**Title: 2-monthly Report from Frimley Health Infection Prevention & Control Teams (the Frimley Park Hospital Infection Control Committee, and Heatherwood & Wexham Park Hospitals Infection Control Committee)**

**Purpose: To report to the Board of Directors on Frimley Health infection control performance 2015/16 to date**


**Summary:** *All data correct as at 22/2/16*

MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemia
There has been two post-48 hour cases to date at Wexham Park Hospital, which were both agreed to be unavoidable at Post-Infection Review.

*Clostridium difficile* Infection (CDI)
To date there have been 40 Trust-apportioned cases against a target of 31 (23 at Wexham Park Hospital and 17 at Frimley Park Hospital). Root Cause Analysis of the cases to date have identified 13 lapses in care (9 at FPH, 4 at WPH), 12 of which related to antibiotic prescribing that did not comply with Trust guidelines.
To date, there have been six 'periods of increased incidence' (PII) (WX5, WX7, G9, Critical Care and two on F9).

Meticillin sensitive *Staphylococcus aureus* bacteraemia
To date there have been 28 hospital-apportioned cases (11 at Frimley Park Hospital, 17 at Wexham Park Hospital).

*Escherichia coli* bacteraemia
To date there have been 457 cases. The majority were community-onset infections, associated with non-healthcare-related UTIs.

Hand Hygiene
A summary of the hand hygiene audits completed in the January-March 2016 quarter (to date) by the Infection Prevention & Control Nurses to observe compliance with the '5 Moments for Hand Hygiene' (all staff groups) is:
Frimley Park Hospital = 93%, 'Bare below the elbows' = 96%. The group "doctors" improved in December but have dropped to 82% in Jan and Feb to date. "Unregistered nurses" have improved to achieve 90%.
Heatherwood and Wexham Park Hospitals = 77%. The group "doctors" scored only 38%, and the Deputy Medical Director has emailed all Consultants to remind them of the importance of compliance with the 5 moments for hand hygiene. "Unregistered nursing staff" scored 65%. It has been noted on ward visits that this score has been brought down when unregistered nursing staff fail to remove their gloves and clean their hands after completion of a task. This can easily be improved if gloves are removed when no longer required so that hands can be cleaned.
As a large majority of infections are transmitted by hands, hand hygiene is a patient safety priority. Improvment must continue in order to prevent ward closures due to norovirus or influenza, to prevent spread of drug-resistnat organisms - and to ensure continued reduction in cases of Cdiff and MRSA bacteraemia.

Antimicrobial Prescribing Stewardship
There has been collaborative work by Microbiology and Pharmacy to align the antimicrobial policies across all three sites, and the updated guidelines were launched, along with the Micro Guide, on 18th November (Antibiotic Awareness Day) and is now in use by the Trust. The results of the 'short-timeframe' audits have not shown significant improvement in the past year, and a revised (more qualitiative) audit proforma is being reviewed at the next Antimicrobial Stewardship Group, with the plan that it will provide more useful data on which Directorates can take action, rather than providing simply an over percentage score.

Short term, non-tunneled CVC infections
No infections for the year to date at Frimley Park Hospital.
The planned commencement of data collection at Heatherwood and Wexham Park Hospitals in December, had been delayed due to lack of resource in the Infection Prevention and Control Team to collect this data. A Band 7 Infection Control Nurse has been appointed and is due to start working at HWP in May.

TPN related Peripherally inserted Central Catheter infections
There has been two cases for the year to date identified at Frimley Park Hospital.

The planned commencement of data collection at Heatherwood and Wexham Park Hospitals in December has been delayed until the Infection Prevention and Control Team at Wexham is fully resourced to collect this data. A Band 7 Infection Control Nurse has been appointed and is due to start working at HWP in May.

Orthopaedic Mandatory Surgical Site Infection Surveillance (SSIS)
The SSI surveillance data is still being entered, but the predicted rates for Frimley Park Hospital for the Oct-Dec 15 quarter are 0.76% for hip replacements and 0% for knee replacement categories.
The SSI rates for Heatherwood and Wexham Park for the April-June 15 quarter were 0% for hip replacements, and 0.9% for knee replacements.

Facilities and Estates issues
At FPH, advice has been provided on how any infection risks can be mitigated during the corridor roof maintenance works in Theatres.
Heatherwood Theatres 1, 2 & 4 had failed their ventilation verification, and were closed until remedial works carried out. Theatre 4 is currently in use for non-Orthopaedic work until the laminar flow has passed its verification.

Siderooms & Bed Spacing
The demand for side-rooms on Surgical wards at FPH has continued to outweigh the availability, and has led to the cohorting of patients colonized with multi-resistant organisms in bays on F7, F8 and Gynae on a number of occasions. The infection control team carry out ward rounds and liaise with the bed management team to ensure patients are safely placed based on an isolation scoring toolkit. Insufficient side-room availability on the Gastro-Medical wards was raised as a significant risk for further CDI cases on F9. In January-February, around 110 side-rooms are required each day for the isolation of patients for infection prevention and control reasons.
Although an improvement has been noted in the size of bed spaces in newer hospital estate, a number of new builds and ward refurbishment plans have been unable to be signed off by the Infection Prevention & Control Team for several years, due to not meeting the required standards. The spacing in the 4-bedded bays in the current Wexham Park Maternity Plans are non-compliant with National guidelines. However a risk assessment is carried out during building planning to balance the number of new beds required, with the guidelines for sufficient bed spacing for infection prevention and control and Health & Safety, and is referred to the Board as required for a final decision.

The on-going delay in the implementation of ICNet at Heatherwood and Wexham Park sites has had an impact on the ability of the IPCT to pro-actively monitor patients for alert organisms and conditions. This is still the subject of contractual negotiation with the supplier.

Further pressure has been put on side-rooms across the Trust from the beginning of February, as a late start to the influenza season, has seen an increase in patients admitted with 'flu-like symptoms, requiring isolation. Norovirus has caused outbreaks at a number of local hospitals and care homes, and Wexham Park managed one small outbreak requiring a short closure on Ward 4.

Norovirus
FPH – no ward closures to date.
HWHP -The female side of Ward 4 (Wexham) was closed to new admissions between 11/2/16 and 18/2/16 with 8 patients affected by norovirus.

Staffing
FPH: The Nurse Consultant resource has been spread across all sites since October 2014. All Microbiology posts are filled.
HWP Hospitals: The Infection Control Doctor post is currently advertised. Two Locum Microbiology Consultants are in post to support the two substantive Microbiology Consultants.
Two nursing team posts are currently vacant, however there has been one successful applicant to one of these.

**Recommendation:**
Members are asked to discuss and note this Report.

**Prepared by: Amanda Walker (Infection Prevention & Control Nurse Consultant), Vicky Gentry (Infection Prevention & Control Nurse Specialist), & Jenny Wyeth (Lead Infection Prevention & Control Nurse)**
**Presented by: Ian Fry (Director of Infection Prevention and Control)**

MRSA bacteraemia

The 2015/16 objective for the Trust is zero-tolerance for MRSA bacteraemia cases. There has been two post-48 hour cases to date at Wexham Park Hospital, which on Post-Infection Review (PIR) were both agreed to be unavoidable. A fine of £10k has been applied for each case by NHS Windsor, Ascot & Maidenhead CCG. There have been seven pre-48 hour MRSA bacteraemia cases (3 at FPH, 4 at WPH). Of these, three have been assigned to a third party, and four have been assigned to the community/ CCG.

*Clostridium difficile* infection (CDI)

To date there have been 40 hospital-apportioned cases against an objective of 31 (23 at WPH and 17 at FPH).
Consultants whose patients have a 'Trust-apportioned' CDI attend a formal Root Cause Analysis meeting (chaired by the Medical Director) where their prescribing is checked in detail. They also attend a Board meeting to discuss the case directly with that Committee. RCA of the cases to date have identified 13 lapses in care (9 at FPH, 4 at WPH), 12 of which related to antibiotic prescribing that did not comply with Trust guidelines, and one relating to lack of hand hygiene consumables in a side-room at FPH (although this was not the root cause of the infection). A summary of the RCA findings can be found in Appendix A.
To date, there have been six 'periods of increased incidence' (PII) as defined by DH guidance ("*Clostridium difficile* How to Deal with the Problem" 2008): on WX5, WX7, G9, FPH Critical Care and two on F9.
The FPH Critical Care PII was originally classed as a CDI outbreak, as the same strain was identified in the two patients affected, an outbreak meeting was held 3/12/15, and an action plan raised. At the beginning of January, it was confirmed the Reference Laboratory had made an error with the reporting, and it was in fact two different strains of *Clostridium difficile* involved, and the outbreak investigation was closed. It is important to acknowledge that the actions raised by the outbreak action plan are also key in the prevention of further CDI PII and issues with GRE within the hospital.
Multidisciplinary CDI ward rounds take place at FPH on Wednesdays, led by a Gastro Medicine Consultant, and supported by a Microbiology Consultant, IPCN, Pharmacist and Dietician. It is aimed to roll this programme out at Wexham, once the Gastro resource has been identified to support this.

*Meticillin sensitive Staphylococcus aureus* bacteraemia

There is no objective set for the Trust for 2015/16. To date there have been 28 hospital-apportioned cases (11 at FPH, 17 at WPH). The source of four of the eight cases at FPH were thought to be from peripheral IV device infections.

*Escherichia coli* bacteraemia

There is no objective set for the Trust for 2015/16, and the cases are neither apportioned to community nor hospital. There have been 457 cases to date, the majority (90%) of cases were acquired prior to hospital admission, and were associated with UTIs which were not healthcare-related. Cases which were assessed to be possible or likely HCAIs, associated with the patients' current admission, make up only 4% of the total cases (the root cause of these was: catheter-associated infection, biliary sepsis, wound infection, chloecystitis, aspiration pneumonia, cholangitis, liver abscesses and infected collection post hemicolectomy), and the remaining 6% of post-48 hour cases were not healthcare-associated.

Hand Hygiene

Monitoring of compliance with the Trust Hand Hygiene policy and the WHO's (2009) '5 Moments for Hand Hygiene':
FPH: January-March 2016 (to date) = 92%. An improvement has been observed in the compliance from unregistered nursing staff, but education and support continues for this staff group as the compliance has not been higher than 90% in over a year. Compliance from clinical staff being 'Bare Below the Elbows' for patient care has improved to 96%. The group "doctors" improved in December but have dropped to 82% in Jan and Feb to date. "Unregistered nurses" have improved to achieve 90%.

Heatherwood and Wexham Park Hospitals = 77%. The group "doctors" scored only 38% and the Deputy Medical Director has emailed all Consultants to remind them of the importance of compliance with the 5 moments for hand hygiene. "Unregistered nursing staff" scored 65%. It has been noted on ward visits that this score has been brought down when unregistered nursing staff fail to remove their gloves and clean their hands after completion of a task. This can easily be improved if gloves are removed when no longer required so that hands can be cleaned. "Registered nursing staff" scored 82%.
As a large majority of infections are transmitted by hands, hand hygiene is a patient safety priority. Improvment must continue in order to prevent ward closures due to norovirus or influenza, to prevent spread of drug-resistnat organisms - and to ensure continued reduction in cases of Cdiff and MRSA bacteraemia.

Antimicrobial Prescribing Stewardship

The governance arrangements for antibiotic stewardship have been changed so that there is a single cross-site Antibiotic Group, and an action plan for improvement (with short and long term timeframes) is the responsibility of that committee which reports directly to the Drugs and Therapeutics Committee. This then feeds to the Clinical Governance Committee (which is chaired by the Medical Director), and then to the Executive Board.
There has been collaborative work by Microbiology and Pharmacy to align the antimicrobial policies across all three sites, and the updated guidelines were launched, along with the Micro Guide, on 18th November (Antibiotic Awareness Day) and is now in use by the Trust. The Medical Director, Microbiology and Pharmacy have been proactive in the promotion of antimicrobial stewardship to clinicians, which is paramount in the prevention of CDI and development of antimicrobial-resistant bacteria. RCA of CDI and GRE cases in the hospital have highlighted the need for clinicians to contact Microbiology for advice if their patients require courses of antibiotics longer than 5 days, if the patient has received multiple courses of antibiotics in the preceding months, or if the case is considered complicated.

The December 2015 quarterly antibiotic prescribing audit carried out by the FPH Pharmacy was presented in the January 2016 Board paper, showed an overall improvement in the compliance with the prescribing bundle from the September audit at FPH, to 74%. The results of the 'short-timeframe' audits have not shown significant improvement in the past year, and a revised (more qualitiative) audit proforma is being reviewed at the next Antimicrobial Stewardship Group, with the plan that it will provide more useful data on which Directorates can take action, rather than providing simply an over percentage score.

Death certificates with MRSA or CDI recorded as Primary or Secondary Cause 2015/16

| | **MRSA** | | ***Clostridium difficile*** | |
|---|---|---|---|---|
| | **FPH** | **WPH** | **FPH** | **WPH** |
| April 2015 | | | | Part II |
| May 2015 | | | | Part II |
| June 2015 | | | | |
| July 2015 | Part II | | | Part II |
| August 2015 | | | | |
| September 3015 | | | | |
| October 2015 | | | 2 x Part II | Part 1b, and Part II |
| November 2015 | | | Part II | |
| December 2015 | | | | |
| January 2016 | Part 1a | | | |

The death certificate with MRSA recorded as part 1a, was a community-apportioned MRSA bacteraemia case, and is being reported as a serious incident by the relevant CCG. The one death certificate at FPH with MRSA recorded on Part II, was for a patient with a 15-year chronic sinus from an infected hip replacement (although had no MRSA positive results at FPH since 2000). Death certificates in with *Cdiff* recorded as Part II, were discussed with a Consultant Microbiologist, and the one death certificate where is was recorded as Part I, was discussed at RCA.

Short term, non-tunneled CVC infections
There have been no cases to date at Frimley Park Hospital, in either Critical Care or the rest of the hospital. Work is underway to ensure a similar programme of monitoring for these infections at Heatherwood and Wexham Park Hospitals is in place as per the Annual Plan and Annual Audit Plan for 2015-16 which was approved by the Trust Board. This had been delayed due to lack of resource in the Infection Prevention and Control Team to collect this data. A Band 7 Infection Control Nurse has been appointed and is due to start working at HWP in May.
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TPN related Peripherally-inserted Central Catheter (PICC) infections
There has been two TPN-related PICC infections to date at FPH, one case on F8, and another in a Gastro-Medicine case on F7 Urology. Work is underway to ensure a similar programme of monitoring for these infections at Heatherwood and Wexham Park Hospitals is in place as per the Annual Plan and Annual Audit Plan for 2015-16 which was approved by the Trust Board. This had been delayed until the Infection Prevention and Control Team at Wexham is fully resourced to collect this data. A Band 7 Infection Control Nurse has been appointed and is due to start working at HWP in May.

Orthopaedic Mandatory Surgical Site Infection Surveillance
Public Health England has now confirmed that although SSIS data continues to be reported by hospital site, the annual national publication will merge the data to report the SSI rates as Frimley Health.

FPH: The SSI data for the October-December 15 quarter is still being entered, but the predicted SSI rates are 0.76% for hip replacement categories (one deep SSI) and 0% for knee replacement.
HWP: The SSI rates for the April-June 15 quarter were 0% for hip replacements, and 0.9% for knee replacements. The data for the July-September quarter is not yet available.

Facilities and Estates Issues

At FPH, the IPCT were involved in meetings about the corridor roof maintenance works in Theatres, and provided advice on how any infection risks can be mitigated during the works. The 'Deep Cleaning' programme is currently on track, with only one room a month behind its scheduled clean.
At HWP, issues were raised about Heatherwood Theatres 1, 2 & 4, which had failed their ventilation verification. The Theatres were closed until remedial works carried out. Theatre 4 is currently in use for non-Orthopaedic work until the laminar flow has passed its verification.

Siderooms & Bed Spacing

The demand for side-rooms on Surgical wards at FPH has continued to outweigh the availability, and has led to the cohorting of patients colonized with multi-resistant organisms in bays on F7, F8 and Gynae on a number of occasions. The infection control team carry out ward rounds and liaise with the bed management team to ensure patients are safely placed based on an isolation scoring toolkit. Insufficient side-room availability on the Gastro-Medical wards was raised as a significant risk for further CDI cases on F9. In January-February, around 110 side-rooms are required each day for the isolation of patients for infection prevention and control reasons.
Although an improvement has been noted in the size of bed spaces in newer hospital estate, a number of new builds and ward refurbishment plans have been unable to be signed off by the Infection Prevention & Control Team for several years, due to not meeting the required standards. The spacing in the 4-bedded bays in the current Wexham Park Maternity Plans are non-compliant with National guidelines. However a risk assessment is carried out during building planning to balance the number of new beds required, with the guidelines for sufficient bed spacing for infection prevention and control and Health & Safety, and is referred to the Board as required for a final decision.

The on-going delay in the implementation of ICNet at Heatherwood and Wexham Park sites has had an impact on the ability of the IPCT to pro-actively monitor patients for alert organisms and conditions. This is still the subject of contractual negotiation with the supplier.

Further pressure has been put on side-rooms across the Trust from the beginning of February, as a late start to the influenza season, has seen an increase in patients admitted with 'flu-like symptoms, requiring isolation. Norovirus has caused outbreaks at a number of local hospitals and care homes, and Wexham Park managed one small outbreak requiring a short closure on Ward 4.

Staffing

FPH: The Nurse Consultant resource has been workingacross all sites since October 2014. All Microbiology posts are filled.
HWP Hospitals: The Infection Control Doctor post is currently advertised. Two Locum Microbiology Consultants are in post to support the two substantive Microbiology Consultants. Two nursing team posts are currently vacant, however there has been one successful applicant to one of these.

**Appendix A: CDI Root Cause Analysis Summary**:

| Month | Ward/ Consultant | Avoidable/ Unavoidable | Root Cause (including severity of CDI) | Comments (including discussion of lapses in care if present) |
|---|---|---|---|---|
| April 1st 2015 Berks Slough | WX 5 (Board meeting August) | Unavoidable | This was agreed to be a mild case which was most likely hospital acquired. The root cause was antibiotic prescribing due to underlying medical condition including Critical Care stay. | No lapse in care |
| April 14th 2015 Bucks Iver | CCU Wexham (Board meeting August) | Avoidable | This was agreed to be a mild case. The root cause was antibiotic treatment | The antibiotic prescribing did not follow Trust prescribing guidelines. In view of this it was agreed the case demonstrated a **lapse in care**. |
| April 28th 2015 Bucks High Wycombe | WX6 (Board meeting August) | Unavoidable | A mild case in an immunocompromised patient. The root cause was antibiotic prescribing that was necessary due to patients underlying medical condition | No Lapse in care<br>Patient CDI positive in same ward in March – but no evidence of cross infection (evidenced by not same ribotypes). |
| May 2015 Berks Windsor | WX3M | Unavoidable | This was agreed to be a mild case. The root cause was antibiotic treatment that complied with Trust policy and was necessary due to underlying medical condition | No lapse in care |
| June 16th 2015 | WX6 | Unavoidable | This was agreed to be a mild case. The cause was unknown (see "comments" box) | No lapse in care<br>No antibiotics prescribed during stay or in 6 months previous<br>Meeting attended by Pharmacist from Medicines Optimisation Team – Berks East CCG |
| June 17th | WX2 | Avoidable | This was a moderate case. The root cause was antibiotic treatment | The antibiotic prescribing did not follow Trust prescribing guidelines. In view of this it was agreed the case demonstrated a **lapse in care**.<br>Meeting attended by Pharmacist from Medicines Optimisation Team – Berks East CCG |
| June 26th Bagshott Surrey | F4 | Avoidable | This was agreed to be a severe case. The root cause was antibiotic treatment | The antibiotic prescribing both prior to, and during admission, did not follow Trust prescribing guidelines. In view of this it was agreed the case demonstrated a **lapse in care**. |
| July 12 2015 Berks, Slough | Eden | Colonisation. Not clinically significant | | RIP in Crit Care on day after positive result |
| July 13th 2015 | G5 | Unavoidable (but could have been community-apportioned if earlier specimen was tested) | This was agreed to be a mild case. The root cause was unknown. This was considered to be a community-onset case identified on late collection of specimen. | *Dr who prescribed antibioitics to discuss the inpatient antibiotic treatment of CAP with Dr Ho in August prior to reporting to Board.* |
| July 16th Berks Slough | WX5 | Unavoidable | This was agreed to be a mild case. The root cause was antibiotic treatment that complied with Trust policy and was necessary due to underlying medical condition (sepsis) | No lapse in care. There were 2 cases on WX5 in July which fits the DH definition for a "Period of increased incidence". The 2 cases were discussed at a "PII" meeting. Ribotyping for both cases was |

| | | | | |
|---|---|---|---|---|
| | | | | different (i.e. no cross infection demonstrated)<br>Meeting attended by Pharmacist from Medicines Optimisation Team – Berks East CCG |
| July 19th Bucks High Wickham | WX2 | Avoidable. | This was agreed to be a moderate case. The root cause was antibiotic treatment that was necessary in an elderly patient who was receiving steroid therapy | Coamoxiclav was prescribed on admission but not documented. No indication or duration documented on drug chart. Dr who prescribed these has now left the Trust. As the prescribing did not follow Trust prescribing guidelines it was agreed the case demonstrated a **lapse in care**. |
| July 22nd Bucks Chalfont St Giles | WX5 | Not clinically significant | This was agreed to be a sample taken from a patient who had received laxatives, and therefore is not clinically significant | No lapse in care. There were 2 cases on WX5 in July which fits the DH definition for a "Period of increased incidence". The 2 cases were discussed at a "PII" meeting. Ribotyping for both cases was different (i.e. no cross infection demonstrated)<br>Meeting attended by Pharmacist from Medicines Optimisation Team – Berks East CCG |
| July 25th Berks Slough | WX17 | Unavoidable | This was agreed to be a mild case. The root cause was antibiotic treatment that was necessary and complied with Trust policy | No lapse in care |
| August 6th Berks, Slough | WX7-AMU | Unavoidable | This was agreed to be a mild case in a patient who has tested positive for CDI more than 28 days previously. The root cause was agreed to be antibiotic prescribing both in the community and the previous hospital admission | No lapse in care |
| August 12th Camberley, Sy | F4 | Unavoidable (for F4) | This was agreed to be a severe case. The root cause was antibiotic treatment | No antibiotic treatment was prescribed on F4, and there were no lapses of care on F4. Antibiotic treatment on previous admissions to G9 & G5 in July did not follow Trust guidelines for treatment of HAP – *Dr who prescribed to discuss the inpatient antibiotic treatment with Dr Ho in August prior to reporting to Board.* |
| August 13th | WX7 | Unavoidable | This was agreed to be a mild case. The root cause was antibiotic treatment that was necessary and complied with Trust policy | C diff not recorded on death cert – agreed to be correct. |
| August 13th Aldershot, Hants | F9 | Pending (see notes in "comment" box) | This was agreed to be a mild CDI case. The root cause of infection was unknown. | Antibiotic treatment for UTI did not follow hospital guidelines, and this was considered to be a **lapse in care**. *No clinician attended the meeting, so further meeting required to identify whether case was as result of antibiotics prescribed.* |
| August 17th Maidenhead, Berks | WX7 | Unavoidable | This was agreed to be a mild CDI case. The root cause of infection was antibiotic treatment that complied with the existing Trust policy (NB the antibiotic policy has been changed in September ). | No lapse in care |

| | | | | |
|---|---|---|---|---|
| September 3rd, Camb, Sy | F4 Mr Wee | Unavoidable | This was agreed to be a mild CDI case. The root cause of the infection was antibiotics required for osteomyelitis and diabetic foot infection | |
| September 8th Bucks | WX ITU | Unavoidable | This was agreed to be a moderate CDI case. The root cause of infection was antibiotic treatment. That was necessary due to patients complex underlying medical condition. | No lapse in care |
| September 8th Bucks | WX1 | Unavoidable | This was agreed to be a moderate CDI case. The most likely root cause of infection was antibiotic treatment. | No lapse in care |
| September 13th Berks | WX3 | Unavoidable | This was agreed to be a moderate CDI case. The root cause of infection was antibiotic treatment which complied with existing Trust policy. It was noted that there was a lapse in antibiotic prescribing but this was after the stool sample was taken and so agreed not a factor in the development of the Cdiff. | No lapse in care |
| September 17th Hants | F2 | Avoidable | This was agreed to be a moderate CDI case. The root cause of infection was antibiotic treatment. | Additional antibiotics were prescribed for UTI, when the original prescription was sufficient. This was considered to be a **lapse in care**. |
| Sept 19th | WX18 | Unavoidable | This was agreed to be a moderate CDI case. The root cause of infection was unknown | No lapse in care |
| October 1st Berks | Parkside Long Stay | Unavoidable | This was agreed to be a severe CDI case. The root cause of the infection was unknown but there was discussion about the possibility of asymptomatic colonisation of patient's defunctioning bowel, which could have caused an opportunistic infection once the bowel was functioning again. | No lapse in care |
| October 9th Hants | F7 Urology | Avoidable | This was considered to be severe CDI.<br>The root cause of the infection was antibiotics prescribed for HAP. | The prescribing of antibiotics for hospital-acquired pneumonia was not in line with FPH policy, and without evidence for the diagnosis of HAP, this was considered to be a **lapse in care**. |
| October 9th Berks | Parkside Long Stay | Unavoidable | This was considered to be mild CDI. The root cause of the infection was antibiotics required for on-going infection and sepsis associated with complicated cholecystitis. As antibiotic treatment was required, the case was considered to be unavoidable. | Antibiotics prescribed for surgical prophylaxis, the use of ciprofloxacin, and the duration of prescriptions, was not in line with FPH policy, and no advice was sought from Micro re. complicated on-going infection. These issues were considered to be **lapses in care**. |
| October 14th Surrey | G9 | Unavoidable | This was case considered to be severe CDI.<br>The root cause of the infection was antibiotics prescribed in the community for an ankle wound. | No lapses in care for FPH. |
| October 30th Berks | G9 | Unavoidable | This case was considered to be a mild CDI.<br>The root cause of the infection was antibiotics prescribed in the | No lapses in care for FPH<br><br>**Ribotype: Cdiff not detected** in specimen by Reference lab – |

| | | | | |
|---|---|---|---|---|
| | | | community for leg ulcers, followed by treatment in hospital required for UTI. The patient has had an extended length of stay in hospital due to her mobility not meeting the requirements to return to the rehab facility from which she was admitted. | false positive result |
| November 5th Berks | Critical Care | Unavoidable | This was considered to be a severe CDI case.<br>The root cause of the infection was antibiotic treatment which were necessary for the patient's underlying medical and surgical conditions. It was likely that the patient had CDI prior to admission, but could not be identified until she had further diarrhoea 4 days into admission. | No lapses in care. |
| November 10th Sy | CriticalCare | Avoidable | This was considered to be a moderate CDI case.<br>The root cause of the infection was antibiotic treatment prescribed during both the current admission and in the 4 months prior to surgery. | There were multiple antibiotic prescriptions for this patient that were discussed to not follow Trust guidelines, either due to lack of stop/ review date, lack of documented indication, inappropriate antibiotic choice or prolonged courses. This was therefore considered to be a **lapse in care**. |
| November 28th Hants | F9 | Unavoidable | This was considered to be a mild CDI case.<br>The root cause of the infection was antibiotic treatment which were necessary for the patient's underlying medical condition. | A **lapse in care** in hand hygiene was agreed due to the lack of a soap dispenser above the hand hygiene sink in the room (there was one situated at the patient sink in the en-suite) – this had not been picked up by any staff in the year post-F9 refurb. |
| November 30th Sy | F9 | Avoidable | This was considered to be a mild CDI case.<br>The root cause of the infection was antibiotic treatment prescribed during the current admission. | Significant **lapses in care** regarding the antibiotic prescriptions, including not following guidelines for pancreatitis, inappropriate prescribing for chest infection, and administration of antibiotics which did not have a legal prescription. |
| December 9th Bucks | GP unit, | Unavoidable | This is a moderate CDI case. The patient was admitted with diarrhoea documented before and on admission. The root cause is antibiotic treatment prior to this admission. | First stool specimen documented as sent on 7/1/16, but no record of this reaching the lab. Failure to check this caused a delay in the commencement of treatment and this was agreed to be a **lapse in care** |
| January 6th Slough | WX5 | Avoidable | This is a second stool sample to test positive 29 days after the first stool tested positive from the same patient as above (therefore it is reportable a second time). The sample was taken after patient had received laxative as part of flexi sig prep. | There was no lapse in care, but there is a learning point that staff should consider if a stool specimen is indicative of infection if the patient has received laxative –and should seek advice if unsure. The positive result did not inform any change in patient care or treatment as he was known Cdiff positive |
| February 3rd Hants | F9 | Unavoidable | This was considered to be a mild CDI case.<br>The root cause of the infection was antibiotic treatment which were necessary for the patient's underlying | No lapse in care. |

| | | | | |
|---|---|---|---|---|
| | | | medical condition. | |
| February 6th Surrey | F9 | Avoidable | This was considered to be a mild CDI case.<br>The root cause of the infection was antibiotic treatment prescribed during the current admission. | There were significant **lapses in care** regarding the antibiotic prescriptions, including not following guidelines for HAP, prolonged course of antibiotics, administration of antibiotics which did not have a legal prescription, and continuing administration of antibiotics past the documented review date. |
| February 11th | Wx CCU | RCA to be booked | | |

Item 20

# BOARD OF DIRECTORS – COVER SHEET

## Meeting Date: 4th March 2016

| | |
|---|---|
| **Title:** | **2016/17 Annual Plan** |

| | |
|---|---|
| **Purpose:** | To Note the Draft Annual Plan Submission |

**Summary:**

The Trust is required to make two submissions of the 2016/17 financial plan:

- **Draft operational plan (8th February)**
- **Final, detailed operational plan (11th April)**

This paper presents the draft operational plan as submitted on 8th February. This will now need to be finalised prior to the April submission.

Specifically, the financial plan will need to be updated to reflect the latest estimation of the 2015/16 outturn; CIP plans for 2016/17; CCG income and activity plans; and the latest version of the intended capital programme for 2016/17. The planned capital programme has already been further refined since the 8th April submission.

**Recommendations:**

**It is recommended that the Board note the submitted draft annual plan and provide any comments as to changes or omissions to be reflected in the final submission in early April.**

| | |
|---|---|
| **Prepared by:** Daryl Gasson | **Presented by:** Martin Sykes |

Committed To Excellence | Working Together | Facing The Future

Frimley Health NHS
NHS Foundation Trust



# Draft Operational Plan for 2016/17

# Frimley Health NHS Foundation Trust

**Version control**

| Version | Changes | Author | Issue date |
|---|---|---|---|
| **1.0** | Final for submission to Monitor | HB/EJ | 7/2/16 |

# Contents

# 1. Introduction

## 1.1 This plan

The purpose of this draft Operational Plan is to set out our activity, quality and financial plans for 2016/17. There is a greater emphasis upon our workforce plans than has been the case in our previous Operational Plans, and this is in line with our strategic objective to 'develop our staff and our culture'. In addition, this draft plan describes the emerging Sustainability and Transformation Plan for Frimley Health.

## 1.2 An integrated Trust

We celebrated our first anniversary as Frimley Health in October 2015. We have worked hard to develop and maintain high quality safe care across our new organisation. The efforts of our staff were recognised in February 2016 with the award of a 'good' rating for the Wexham Park Hospital by the Care Quality Commission (CQC), marking a significant improvement from the 'inadequate' rating published by the in May 2014. The CQC acknowledged the scale of improvement in their Quality Report:

***'Indeed this is undoubtedly the most impressive example of improvement that CQC has observed since our new approach to inspection started in September 2013."*** [i]

Despite our positive achievements we not complacent, and this plan recognises that in 2016/17 we must ensure that these quality changes are sustainable whilst also addressing our financial pressures and dealing with an underlying financial deficit.

## 1.3 Strategic context

Figure 1, below, sets out the Trust's 2016/17 strategic objectives. Our objectives closely reflect the 'triple' aim set out the NHSE Five Year Forward View, with a particular focus upon quality of care and cost control.

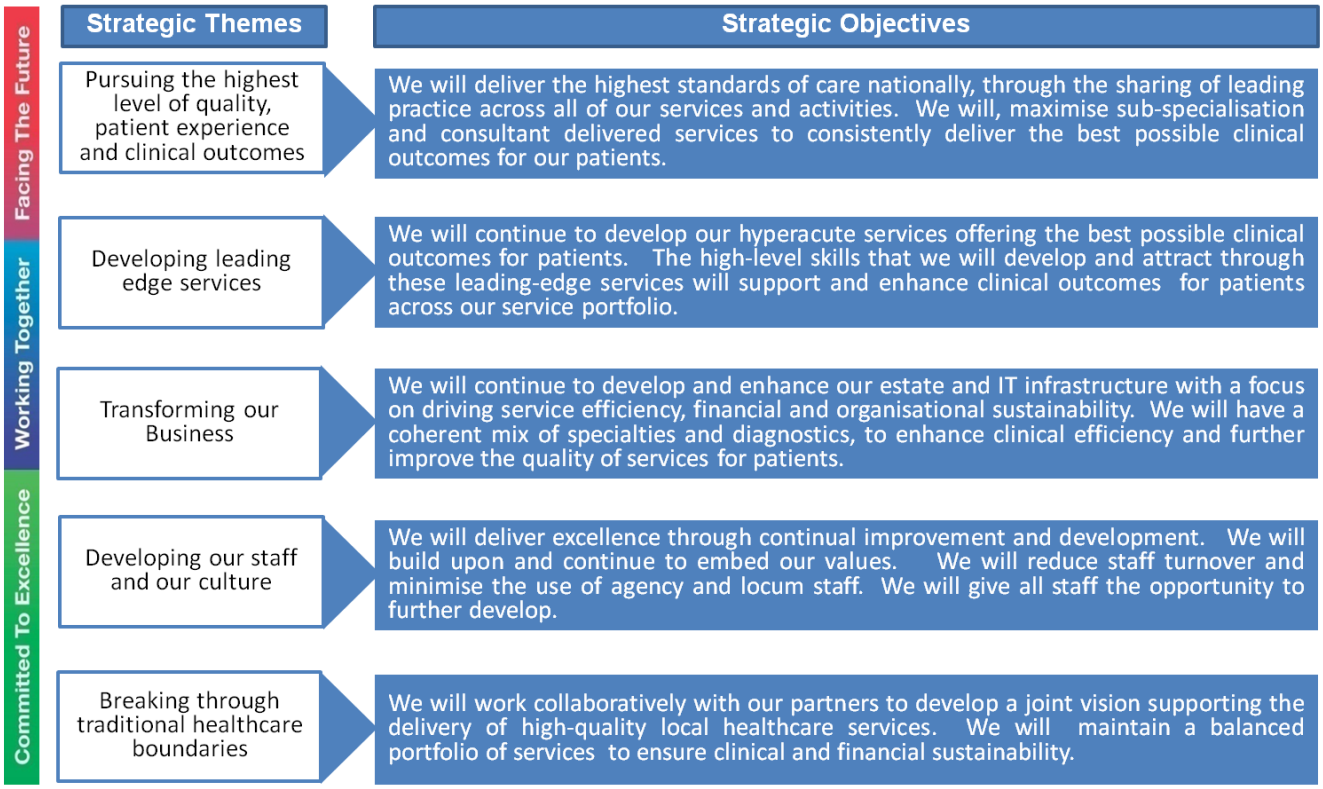



***Figure 1, 2016/17 Trust Strategic Objectives***

These objectives underpin the activity, workforce, quality, financial and strategic plans set out in this Operational Plan.

# 2. Activity and capacity planning

## 2.1 Approach to financial planning and capacity planning

Negotiations with commissioners are being concluded at time of writing. The current position, including the shared set of planning assumptions which have been developed with commissioners is summarised in Chapter 5 of this plan. Moving from one year to the next, contract negotiations tend to include the Trust asking for activity growth to reflect historic trends, and CCGs asking for activity reductions to reflect their schemes for moving activity out of hospital (QIPP and BCF). At this early stage in the planning process we have assumed that QIPP/BCF broadly equals (and therefore cancels out) growth, and this is reflected in our Forward Plan Financial Return and in the narrative description of this found in Chapter 5 of this plan. We will be updating these assumptions in the final version of our Operating Plan and model.

However, the Trust has taken a prudent approach to capacity planning based upon a 'worst case' activity assumption that 2016/17 demand broadly reflects 2015/16 demand and that commissioner schemes do not deliver planned activity reductions. Therefore, our capacity plans, described in section 2.1.3 below allow for greater capacity than the requirement included in the commissioning intentions to date. We do have the ability to 'flex' some of this capacity should it not be required, for example through not taking up our option to use 'winter pressures' beds at Farnham Hospital or escalation areas at Wexham Park Hospital.

The Trust has completed a detailed activity forecast and bed modelling exercise for 2015/16. The forecast has taken account of the following underlying trends in demand and their impact upon performance and capacity requirements:

- 2015/16 forecast outturn data shows a slowing down of the rate of increase for Emergency Medical admissions (NEL admissions) across the Trust when compared to previous years, with NEL activity static at Wexham Park Hospital (compared to an increase of 10% during 2014/15) and Frimley Park Hospital NEL activity increasing by 5%, giving an overall Trust increase of 2%.
- Emergency Department attendances have increased by 3% during the year to date, and again this represents a reduced rate of growth when compared to the same period in 2014/15.
- During the same period elective admissions have increased by 3%, with the greatest increase being seen at Frimley Park Hospital.

Length of stay for 2015/16 year to date remains at a similar level to the 2014/15 outturn for both non elective and elective activity. At a hospital level there has been some improvement in Non Elective length of stays at Wexham Park Hospital. Medical LOS at Frimley Park Hospital has been reduced slightly from 5.37 to 5.26 days.

## 2.2 Demand: planning assumptions and alignment with commissioning intentions

Commissioner intentions were shared with the Trust in December 2015. The Trust's own capacity plans for 2016/17 are sufficient to deliver the level of activity agreed with commissioners to date with a 'buffer' of additional capacity to enable the Trust to cope should demand management schemes not perform as planned. It should be noted that some proposed commissioning schemes, for example frailty pathway redesign and the operational impact of the Vanguard scheme, have not yet been quantified by commissioners. Prudent assumptions for these changes have been included in the Trust's demand and capacity planning to date.

## 2.3 Capacity: Approach to capacity modelling

### 2.3.1 Bed modelling

Two bed models have been produced for 2016/17. A range of scenarios have been modelled, with the recommended approach based on the following assumptions:

- 95% occupancy
- 3% increase in medical spells from 2015/16 levels (in line with 2015/16 forecast outturn)
- 5% increase in surgical spells from 2015/16 levels
- Medical average length of stay of 5.26 days

- Surgical average length of stay of 3.65 days

This model suggests that the following additional beds will be required during 2016/17:

| Capacity | Frimley Park Hospital | Wexham Park Hospital |
|---|---|---|
| Additional medical beds | 26 | To follow |
| Additional surgical beds | 19 | To follow |
| Total additional beds | **45** | |

***Figure 2, 2016/17 Bed model (preferred scenario)***

Some sensitivity testing has been completed as part of this modeling work:

- Based on a 5% increase in medical spells and a LOS of 5.26 there would be an increased bed requirement of 34 at Frimley Park Hospital.
- Based upon an 8% increase in surgical spells and a LOS of 3.65% there would be an increased surgical bed requirement of 21 at Frimley Park Hospital

Our plans to provide this capacity include the development of new physical capacity at Frimley Park Hospital in 2016/17, an option to retain up to 42 beds of additional capacity at Farnham Community Hospital, the maintenance of LOS reductions at Wexham Park Hospital and transformation work to improve our processes internally and to develop better integrated care pathways with our partners. Our current plans are summarised in figure 3, below:

| Capacity | Frimley Park Hospital | Wexham Park Hospital |
|---|---|---|
| Short term additional capacity | • Retain 21 'winter pressures' beds at Farnham Hospital, if required<br>• **Total additional beds: 21** | • Continued use of escalation areas to see if possible to create permanent beds |
| Permanent additional capacity | • 26 bed new medical ward at FPH (G7)<br>• **Total additional beds: 26** | • Re-modelling in June 2016 to inform ward moves in line with site Development Control Plan<br>• Potential release of beds if Commissioners decide to transfer acute stroke service off Wexham Park site<br>• To be included in A&E and MAU rebuild |
| Performance improvement and service transformation | • N E Hants Vanguard project for integrated care<br>• Re-profile Orthopaedic beds to release surgical bed capacity | • Maintain reduced medical LOS at xx, PMO to support this<br>• Transformation programme including frail elderly |

***Figure 3, 2015/16 Additional bed capacity and efficiency improvements***

### 2.3.2 Other capacity plans

The Trust's primary capacity concern for 2016/16 is to ensure the provision of sufficient beds to meet forecast demand and to enable the Trust to meet access targets. However, work is also underway to improve capacity in other areas, either through capital projects or through process improvement and transformation under the leadership of the Trusts Programme Management Office. Key plans include:

- **Emergency Department**: Detailed planning is now underway for the new build of the Emergency Department at Wexham Park Hospital, to provide both additional capacity and improved patient flow. A CT scanner has been installed at Wexham Park during 2015/16 and has already improved patient flow.
- **Theatre utilisation**: Theatre capacity does not have an adverse impact upon the Trust's ability to meet access targets, but work is planned to improve theatre utilisation rates to an average of 80%.

- **18 week referral to treatment:** A programme of process improvements is underway, and this includes improved booking and scheduling process and better management of theatre lists.

### 2.3.2 Use of the independent sector

There are no plans to use independent sector capacity in 2016/17, although this will be used to reduce backlogs of patients awaiting Orthopaedic surgery and Endoscopy and Frimley Park Hospital during quarter 4 of 2015/16.

## 2.4 Delivery of key operational standards

The Trust has performed extremely well against all key operational standards during 2015/16. We have used very similar demand and capacity planning process for 2016/17 to the process that we adopted successfully during 2015/16.

The Trust's primary capacity concerns which may impact upon our achievement of key operational standards in 2016/17 are:

- Ensuring sufficient capacity at Frimley Park Hospital for Endoscopy to enable achievement of RTT and new diagnostic standards
- Ensuring sufficient capacity at Frimley Park Hospital for Orthopaedic Surgery to enable achievement of RTT standards

The capacity constraint for these services is manpower rather than physical capacity and whilst workforce plans are in place for these areas they are still considered to be potential risks to the Trust achieving 2016/17 operational standards for RTT and diagnostics waiting times. This risk is being actively managed by the Trust and Independent sector capacity is being used during quarter 4 of 2015/16 to return the waiting lists for these services to a more sustainable position by the start of 2016/17.

## 2.5 Long range forecasting

Frimley Health recently completed early work to produce detailed model of demand. This will be used in the future to inform a range of activities, including capacity planning, capital planning and the modelling of transformation projects. We are sharing this work with our commissioners and expect to reflect their views in future iterations of our long range forecast. Figure 4 below, shows the scenario based modelling approach that has been adopted.

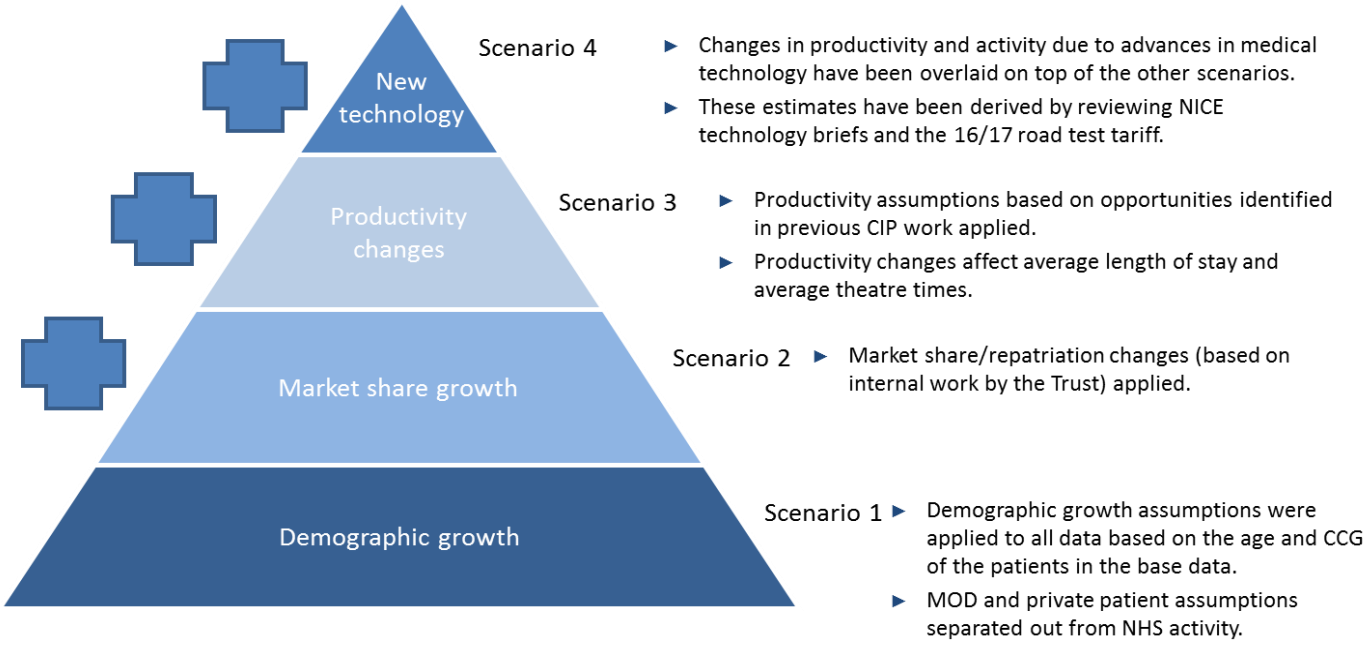



*Figure 4, Long range demand model*

## 3. Quality Planning

### 3.1 Current position

Frimley Park Hospital was the first hospital to be awarded an outstanding rating by the Care Quality Commission (CQC) in 2014. The CQC report highlighted a number of areas of outstanding practice and noted the positive, open and transparent culture developed at FPH as well as examples of what was described as exemplary care throughout many wards and services. A breakdown of the CQC ratings is set out in figure 5, below.

The report suggested that limited improvements could be made in paediatrics by enhancing staffing levels and skill mix. The Trust has now addressed these issues.

| Overall Rating for acute services at Frimley Park Hospital | Outstanding |
|---|---|
| Are acute services at this Trust safe? | Good |
| Are acute services at this Trust effective? | Good |
| Are acute services at this Trust caring? | Outstanding |
| Are acute services at this Trust responsive? | Outstanding |
| Are acute services at this Trust well-led? | Outstanding |

*Figure 5, 2014 CQC ratings for Frimley Park Hospital*

The Care Quality Commission (CQC) inspected Wexham Park Hospital several times during 2014. At this time the hospital received an overall rating for acute service of 'inadequate', with particular concerns expressed about the hospital culture, consistent incident reporting and the Trust's ability to apply learning from incident reports, high use of agency and locum staff and inadequate bed capacity. Following the acquisition a programme of measures intended to improve quality and safety at Wexham Park Hospital was implemented across of a diverse range of areas impacting on the quality of patient experience including patient safety, infection control, safeguarding and complaints management.

The CQC revisited Wexham Park Hospital in October 2015 and released updated ratings in February 2016. The CQC Quality Report recognised the impressive improvements made by the Trust at Wexham Park Hospital and issued updated ratings which are set out on Figure 6, below.

| Overall Rating for acute services at Wexham Park Hospital | Good |
|---|---|
| Are acute services at this Trust safe? | Good |
| Are acute services at this Trust effective? | Good |
| Are acute services at this Trust caring? | Good |
| Are acute services at this Trust responsive? | Good |
| Are acute services at this Trust well-led? | Outstanding |

*Figure 6, 2015 CQC ratings for Wexham Park Hospital*

The Wexham Park Critical Care and Urgent and Emergency Services were rated as 'outstanding' and all other clinical services were rated as 'good. A number of areas for improvement were identified, most notably:

- The Trust should continue to improve staffing recruitment and retention, reducing reliance on temporary staff
- Ensure that The cleanliness of the hospital is audited in line with standards set out in the national specifications for cleanliness in the NHS
- Ensure that the Trust policy around Candour (DoC) is followed when managing incidents that come under this regulation, and that the policy is extended to cover incidents that resulted in psychological harm.

The Trust will now incorporate plans to address these issues into our Quality Improvement Plan for Wexham Park Hospital. Implementation of the plan will be led by the Director of Nursing and Quality and the Medical Director and progress will be monitored at Board level and reported to the public in our Board papers.

## 3.2 National and local commissioning priorities

### 3.2.1 National Priorities

Figure 7, below gives a brief summary of our plans to achieve the 2016/17 'must dos' from 'Delivering the Forward View' and the 2016/17 NHS Mandate. Only those standards which are relevant to acute providers are included and standards duplicated in both sets of priorities are only included once.

| Ref | Deliverable | Currently achieved? | 2016/17 Trust Plans |
|---|---|---|---|
| **2016/17 Acute provider 'must dos' from Delivering the Forward View** | | | |
| 1 | Develop a high quality and agreed STP, deliver the relevant critical milestones during 2016/17 | NEW MEASURE | • Planning underway, good relationships in place to support this along with a history of joint working, e.g. Vanguard, STP |
| 2 | Achieve aggregate financial balance | NO | • As described in Chapter 5 of this plan<br>• Plans include achievement of Agency standards and CIPs which reflect Carter recommendations |
| 4 | Achieve access standards for A&E | YES | • Appointment of additional ED consultants<br>• Planned additional bed capacity |
| 5 | Deliver 18 week Referral to Treatment time | YES | • Use of additional private sector capacity Q4 2016/17<br>• Theatre utilisation & workforce projects |
| 6 | Deliver 62 day cancer waiting time standard | YES | • Maintenance of current performance<br>• Expand chemotherapy facilities at FPH |
| 9 | Develop & implement plans for quality improvement, including publication of Trust avoidable mortality rates (also a requirement of the NHS Mandate 2.1) | YES | • Quality Improvement plans in place, as described in section 3.3 below<br>• FHFT publishes SHMI data and will investigate avoidable mortality reporting |
| **2016/17 Acute provider deliverables from NHSE Mandate** | | | |
| 2.1 | 7 day services: rollout of four clinical priority standards to 25% of population | NEW MEASURE | • All Consultant job plans reviewed and updated, FH already provides a high level of consultant staff onsite at FPH/WPH at weekends and out of hours<br>• Trust audit of current implementation of these standards is underway |
| 2.1 | Make Progress 'Sign up to Safety' | NEW MEASURE | • Campaign launched across FH<br>• Successful bid for £600k, three priorities identified using medico legal claims data |
| 2.1 | Implement recommendations of National Maternity Review in relation to safety | | • Work completed to implement learning from Morecambe Bay review<br>• One of three 'Sign up to safety' priorities is perianal damage reduction |
| 2.1 | Reduction in antimicrobial prescribing | NEW MEASURE | • Ongoing audit to improve compliance with FH guidelines |
| 2.2 | Develop plans to capture and utilise patient feedback in maternity | NEW MEASURE | • Plans under development, to include in final Operational Plan |
| 2.3 | Measurable progress towards six week referral to test standard for cancer | NEW MEASURE | • Progress monitored by Board, steady improvement during 2015/16 |
| 2.3 | Agree trajectory for increase in diagnostic capacity by 2020 and deliver year 1 | NEW MEASURE | • Plan under development for agreement with commissioners |

***Figure 7, Delivery of 'Must do's' from Delivering the Five Year Forward View and NHSE Mandate***

### 3.2.2 Local commissioner and Trust priorities

Local commissioner and Trust priorities largely focus upon the achievement of the National priorities described above. There are in addition a small number of local priorities which will be implemented in 2016/17, in line and these include:

- **Development of an ambulatory care model at Wexham Park Hospital:** Detailed capital planning is underway for the development of a new emergency 'front end' to the hospital, and this is supported by the development of a new model of care, which will support our delivery of access targets and which will support whole system transformation work.
- **Development of 24 hour PCI at Wexham Park Hospital:** 24 hour PPCI service starts at Wexham Park Hospital on 1st April 2016.
- **Cancer pathway reviews:** Frimley Health is currently in discussion with the Royal Berkshire NHS Foundation Trust to develop local Radiotherapy facilities on the Wexham Park Hospital site
- **Potential stroke service changes**: Following a Strategic Clinical Network review in 2015/16, it is possible that the Wexham Park Hospital acute stroke service will not be commissioned in its current form, with acute stroke services provided instead by Frimley Park Hospital and High Wycombe Hospital. This would provide the Trust with additional capacity on the Wexham Park site which could be used to support resilience plans and to ensure that we continue to meet access targets.
- **Seven day working:** The Trust has already made steady progress towards the implementation of 7 day working in particular through the review and update of consultant job plans and rotas to ensure an increased consultant presence on site during evenings and weekends. This supports the delivery of the Association of Medical Royal Colleges' guidance on the responsible consultant.

These improvements have been developed and agreed by the Trust working in partnership with local commissioners and where appropriate with the Thames Valley Strategic Clinical Network. These projects enable us to make progress against our 2015 – 2020 Clinical Strategy, which was described in detail in our 2015/16 Operating Plan and which is summarised in Appendix 1 to this Plan.

In addition, a significant amount of joint work between the Trust and health and care partners is underway to achieve system transformation across the wider health and care economy and this is described in greater detail in Section 6 of this plan.

## 3.3 Approach to quality improvement

The Trust's Medical Director and Director of Nursing and Quality share executive leadership for quality within the Trust.

Quality assurance arrangements during 2015/16 included the development of two site-specific quality committees, to ensure that there is no loss of focus on the Frimley Park site. The committees drive quality improvement across Frimley Health, and on a monthly basis they:

- Review clinical dashboards for each specialty, presented by the Chiefs of Service. The dashboards use an assessment framework reflecting the Care Quality Commission's five domains: safe, effective, caring, responsive and well-led
- Review presentations on morbidity and mortality across the hospitals
- Receive quarterly patient safety reports

The Medical Director chairs these groups and provides assurance to the Board on quality improvement, through the Board Quality Assurance Committee. Following the greatly improved 2015 CQC assessment of the Wexham Park Hospital described at the beginning of this chapter we will integrate the two site-specific quality committees early in 2016/17 into a single, organisational committee. This is in line with the plans set out in our acquisition Full Business Case.

The Frimley Health Board papers provide further assurance on the Trust's quality performance and include a monthly update on the quality improvement plans for all hospital sites. Monthly quality and performance reporting to the Trust Board includes a number of quality Key Performance Indicators across each of the five CCQ domains, including:

- **Safe:** MRSA, VTE assessments, never events
- **Effective:** e.g. SHMI, CRAB Medical Practice Trigger Trends
- **Caring:** e.g. Friends and Family test and more detailed local surveys
- **Responsive:** e.g. A&E target, cancer standards

A significant investment has been made in ensuring that services are well led, with the provision of leadership training to Chiefs of Service, Heads of nursing, Matrons and Ward sisters over the past 18 months.

Frimley Health uses a Plan, Do, Study, Act quality improvement methodology to test changes in practice. The Quality Improvement Programme is supported by the practice development team and our clinical educators.

#### 3.3.2 2016/17 quality priorities

The timing for submission of this draft Operating Plan is not aligned with the Quality Account and Quality reporting processes. Frimley Health is still discussing our three quality priorities for 2016/17 and we will confirm these in our final Operating Plan when this is submitted in April 2016.

The Trust has launched the 'Sign up to safety' campaign. We have already identified our three most important safety priorities as part of a successful bid for £600k of NHSE funds. This bid has provided us with funding to address the three most common issues raised in medico legal claims at Frimley Health over a three year period from 2015 - 2018. We are working to:

1. Reduce perineal damage in maternity patients
2. Improve our consenting process, including sharing information on risks and benefits
3. Improve the clinical handover process

### 3.4 Quality impact assessment process

Frimley Health has developed a robust, gated process for the development and approval of Cost Improvement and other Improvement programmes. Cost Improvement Schemes are identified annually within each Directorate by the Associate Directors in partnership with Specialty Chiefs of Service. Nursing schemes are developed jointly by the Director of Nursing and the Deputy Directors of Nursing.

Efficiency opportunities are then subject to a scrutiny and validation gateway process. This is set out on figure 8, below. At gateway three, the Associate Director is responsible for ensuring that a project charter and Quality Impact Assessment is completed and passed to the Director of Nursing and Medical Director for review and sign off.

At the end of the financial year, the Finance team prepares a CIP report for Board which provides an overview of the value of schemes for the next financial year, together with an assessment of the risk associated with the delivery of those schemes and assurance regarding the QIA approval status. In year the Board receives a monthly CIP delivery update report.

The Trust governance process described above is also followed for improvement programmes such as Sign Up to Safety and seven day working. Scheme briefing papers are presented (as appropriate) to either the Quality Committee, Hospital Executive Board and/or Trust Board for scrutiny and approval. In year monitoring is defined during the project initiation phase and follows the Trust Governance processes.

| | Gateway 1 | Gateway 2 | Gateway 3 | Gateway 4 | Gateway 5 |
|---|---|---|---|---|---|
| **Gateway Headline** | **Initial Estimate** | **Supported by costing, quality impact assessed and validated by Finance & activity team** | **QIA approved and Project Plan approved by Director of Ops** | **Project Plan 75% complete** | **Savings removed from budget** |
| Risk Adjustment | 0% | 20% | 65% | 80% | 100% |
| Activities to complete | Scheme Description, Initial Scheme Value, Initial Scheme Profiling for 15/16, Scheme Risks and Issues, Template completed and submitted | Validated by Finance, validated by activity team, validated for workforce impact, Quality Impact Assessment | QIA approved by Medical Director and Nursing Director. Project Charter completed and appended to QIA to provide DON & MD information to make an informed decision to sign off QIA. | Project Plan completed to 75%, project progress reviewed by Director of Ops, financial performance reviewed by Director of Finance | CIP value removed from budget. Oversight by Director of Finance. |

*Figure 8, Quality Impact Assessment process and gateways*

### 3.5 Risk assessment

Figure 9 below sets out the three most significant risks to quality that we have identified for 2016/17. These will be subject to review as part of our quality account/quality planning process and may be updated in the final version of this Operating Plan in April 2016.

| Mitigating actions | Assurance |
|---|---|
| **1) Risk that emergency pressures will have a negative impact upon quality of care** | |
| • Wide range of quality and safety measures in place e.g. support the deteriorating patient etc.<br>• Daily monitoring of safe staffing levels<br>• Development of ambulatory care model | • Monthly Board report on Quality and Activity<br>• Oversight and scrutiny by the Board Quality Assurance Committee |
| **2) Risk that medical and nursing staffing levels will have an adverse impact upon quality of care** | |
| • UK and overseas nursing recruitment plans, described in Chapter 4 of this Operating Plan<br>• Staff retention plans, including staff survey action plans and organisational development support | • Monthly workforce reports to Trust Board which include staffing and vacancy levels<br>• Directorate level workforce reporting and monitoring<br>• Inclusion on the Trust Assurance Framework, and monitoring of action plan |
| **3) Risk that the Trust does not achieve optimum management of the deteriorating patient** | |
| • EDOS and MET scoring and reporting<br>• Case reviews at Morbidity & Mortality Groups | • Monthly Board report on Quality and Activity<br>• Oversight and scrutiny by the Board Quality Assurance Committee |

*Figure 9, Key quality risks*

### 3.6 Triangulation of indicators

The Trust wide risk assurance framework, together with the integrated Trust Board activity and quality and financial reports enables the Board to triangulate quality and safety measures with workforce indicators to identify areas of risk. The Trust's draft 2016/17 Forward Planning Financial return currently recognizes that our plans across these three areas triangulate, with the exception of our planned spend on bank and agency staff, where we are forecasting a significant reduction based upon the plans described in chapters 3 and 4 of this draft Operating Plan.

# 4. Workforce planning

## 4.1 Planning process and governance

Our workforce planning process is led by the Human Resources Team, who engage with Clinical Associate Directors and Department Heads and Human Resource Business Partners to ensure that our workforce plans and submissions to the LETBs reflect:

- Current workforce pressures, for example pressure in particular departments
- Strategic plans for the future, for example long term reduction in 'back office' staff as a result of the acquisition
- CIP requirements, for example the need to increase permanent nursing staff complement to reduce reliance on agency staff

The workforce plan is signed off as part of the Operational Plan approval process.

An Operational Workforce Group has recently been established at Frimley Health, with membership including the Medical Director and Director of Nursing and Quality. This will ensure that our workforce planning process benefits from senior clinical leadership.

The HR team are involved in the development of CIPs which have an impact on staff numbers or roles and they are also involved in the development and sign off of any business case which has an impact of workforce. Workforce CIPs are scrutinised and monitored alongside all other Trust CIPs using the process described in chapter 3, above.

## 4.2 Workforce transformation

Figure 10, below, gives a summary of our workforce transformation and productivity schemes, and these are then described in greater detail in the subsequent paragraphs.

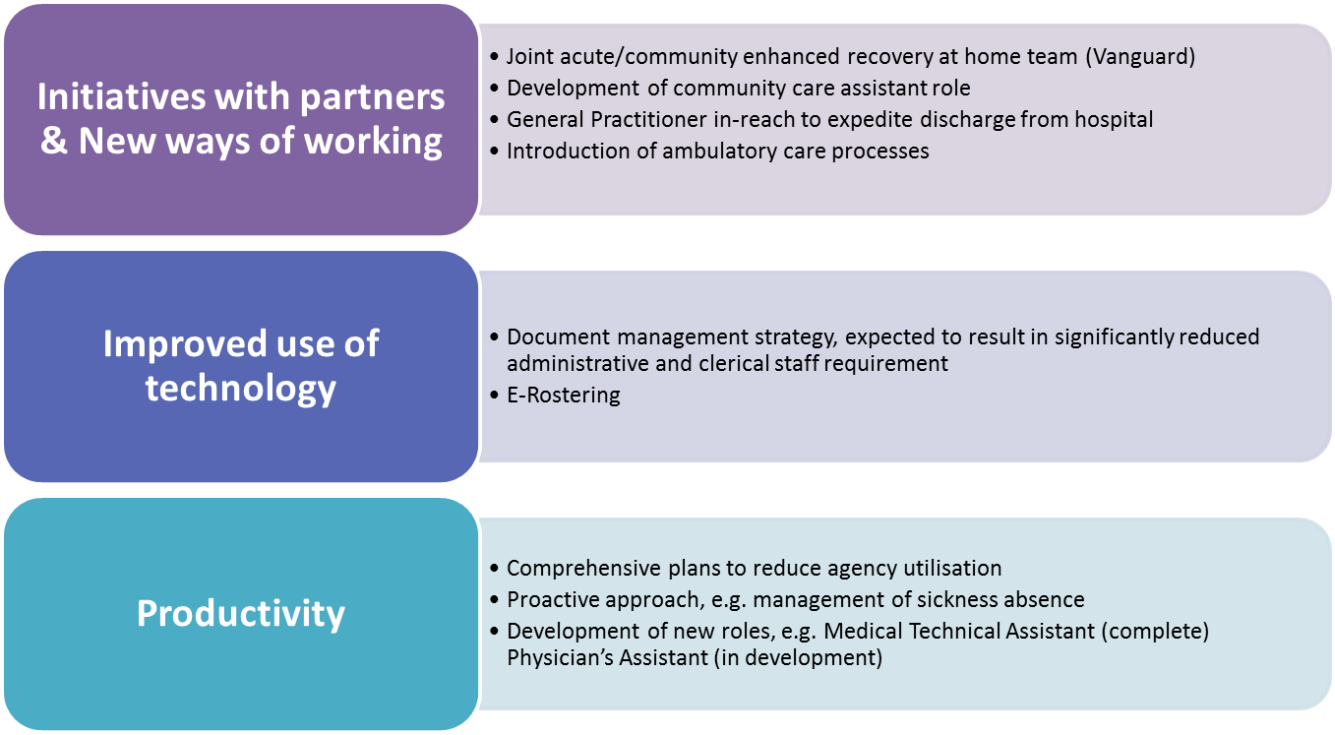



*Figure 10, Workforce transformation initiatives*

### 4.2.1 New ways of working

We have developed a number of new ways of working with our partners in CCGs, social care and at community providers, each of which supports hospital productivity. One example of this includes the development of a

community care assistant role, in which the Trust employs care staff who are then seconded to provide reablement and other home based care for Surrey Social Services. This supports us to reduce our level of delayed transfers of care.

### 4.2.2 Improved use of technology

**E-rostering and reduced reliance on agency staffing**

At the time of the acquisition both legacy Trusts used the same E-rostering system, although they were using different versions and the system was being used in different places. During 2015/16 a project has been implemented to harmonise both the systems and the way that they are used. By April 2016 a single cloud based version of the E-rostering system will be in place and this will interface with the payroll system. As part of this project all rosters are being re-validated.

The single e-rostering system will follow the Frimley Park Hospital model of linking to the FH Bank staffing office, and all requests for temporary staff will be sent directly to the bank. This is a change from the previous Wexham Park Hospital system, in which there was no internal bank and all requests for temporary staff were sent directly to NHS Professionals. The FH bank will be increased to maximize the use of bank staff across the Trust. The business case for the e-rostering project demonstrates that the use of bank staff instead of agency staff at Heatherwood and Wexham Park Hospitals is expected to provide a CIP saving and this is reflected in our CIP programme.

The way in which locum medical staffing is procured is also being harmonised and improved across Frimley Health. During 2016/17 reliance on NHS Professionals at Wexham Park Hospital will be reduced and all locum requests will be handled by the Trust's Medical Staffing Team as was the case at Frimley Park Hospital. This will reduce usage of NHS Professionals and related expenditure on agency premia.

Frimley Health has recently updated the Trust temporary staffing policy, and this has been approved by the Trust Board. The policy includes the process for managing the Monitor requirement for a cap on agency staff usage. An approvals process is in place under which the Directors of Operations sign off any shifts which are over the agency cap or which use non-framework agencies, and this reflects the process required by Monitor.

**Document management**

The Trust is in the process of implementing a new document management system. This will significantly reduce the requirement for administrative and clerical staff in some areas of the Trust, including in medical records.

### 4.2.3 Workforce productivity

A number of workforce productivity targets are in place across Frimley Health and these are reflected in our annual Trust Objectives and/or are reported in the monthly quality and performance report, both of which are subject to Board oversight. Workforce productivity measures include:

- Sickness absence rate of below 3.2%
- Agency spend of below 8% of pay bill
- Overall turnover of below 14.5%
- Nursing turnover of below 16.0%

The Cost Improvement Programme set out in Chapter 5 of this report includes some CIPs which are based on the achievement of these productivity targets, in particular the reduction in agency expenditure and these CIPs are also reflected in our 2016/17 Forward Plan Financial Return to Monitor. Our plans to reduce agency expenditure during 2016/17 are well advanced, and include the following:

- Overseas nursing recruitment plans, including recruitment of 130 additional nurses from the Philippines and Europe
- UK recruiting strategy in place, supported by revised benefits package
- Retention plans, including staff survey action plans and organisational development support

The HR team produces monthly reports for each department giving details of performance against workforce performance and wellbeing indicators, including staff survey feedback. Department Heads and HR Business Partners are able to put in place interventions to improve performance, for example if reported stress levels are high in particular departments an audit is completed to identify the causes of this stress and an action plan is put in place to address these. Consultant productivity is measured by Clinical Directors as part of the annual consultant appraisal cycle.

Historically we have developed new roles at Frimley Park Hospital where necessary to support productivity and to ensure that our skill mix of staff offers optimum value for money. In the past we have created roles such as night nurse practitioner and Medical Technical Assistant, and in 2016/17 we plan to explore and develop if appropriate the role of Physician's Assistant.

The final version of this Operating Plan will include further detail about the quantified impact of these initiatives upon our workforce plan for 2016/17, as summarised on our Forward Plan Financial Return and in Chapter 5 of this draft Operating Plan.

### 4.3 Management of risk

A Local Risk Assurance Framework is in place within the Human Resources Directorate and this captures all workforce related risks, including those relating to vacancy rates and any operational and quality risks related to the bank staff cap. The HR risk assurance framework is reviewed on a monthly basis by the Trust's Corporate Governance Group and significant risks are included on the Trust wide risk assurance framework which is reviewed on a monthly basis by the Trust Board.

The Trust wide risk assurance framework together with the Trust Board activity and quality and financial reports enables the Board to triangulate quality and safety measures with workforce indicators to identify areas of risk.

# 5. Finance

## 5.1 Bridge analysis

At the start of 2015/16 the Trust had planned for a deficit of £14.2m. At month 6 the Trust had managed to keep costs and CIP broadly to plan but was over recovering income. A revised plan was submitted to Monitor improving the position to a £12m deficit.

For the full year income is expected to be above original forecast by £11.4m and expenditure £9.2m above forecast. This will allow the operational deficit of £12m to be achieved.

However, £10m additional in year cash support has been secured from DH and £3m of capital underspend has been converted to revenue. This additional £13m cash supported revenue will mean the Trust shows a £1m surplus on the face of the I&E account for 2015/16.

**The latest forecast for the 2015/16 combined outturn is for a surplus of £1m, which is £15m better than had been originally projected at the start of the year.**

The £9.2m adverse movements on costs is explained by a number of key elements:

- The Trust has planned for 2015/16 CIPs to deliver £24.5m of savings. As reported elsewhere, the projected combined CIP position is forecast to provide a £2.1m shortfall against plan.
- 2015/16 synergies had been anticipated to deliver £2.3m of in-year savings; slippage has reduced this to £1.8m in year, a shortfall of £0.5m
- The balance of the movement reflects the use of agency/locum staff (on all sites) has not decreased to the extent that had been planned. Whilst some of this relates to transaction posts (and is therefore funded); and some is already counted in CIP under delivery; costs associated with increased income has meant the use of agency in unfunded posts and in expensive consultant locums.

The £11.4m increase in income comprises £9.8m of activity related overperformance mainly in non-elective Buckinghamshire and Berkshire and £1.6m of Vanguard and Winter Pressure monies.

| | |
|---|---|
| **Original Deficit Projection:** | **-£14.2m** |
| Under delivery of CIP | -£2.4m |
| Under delivery of Synergies | -£0.5m |
| Other cost increases (agency) | -£6.3m |
| Improvement in net income | +£11.4m |
| Additional DH funding | +£13.0 |
| **Projected closing surplus** | **£1.0m** |

The above figures are best estimates at this point in time as the year end income position has not been agreed with CCGs and the risk of cost overspends in Q4 remain high if winter demand surges are experienced.

## 5.2 Income and Expenditure forecast

There are a number of factors that need to be adjusted in moving from the 2015/16 outturn to the 2016/17 opening position. These are mainly the removal of non-recurrent costs and income, including one-off winter pressures funding and costs, one-off acquisition costs, and ongoing (but non-recurrent) integration costs and income.

Moving into 2016/17 itself, there are also a number of changes, including changes in the national tariff, cost inflation, new cost pressures and the trust savings programmes.

The anticipated impact of these changes had been summarised in the table below, with key items described in more detail later:

| Surplus/Deficit Bridge | | | Income Bridge | Expenditure Bridge |
|---|---|---|---|---|
| **Opening Deficit** | **1.0** | | **621.7** | **(620.7)** |
| 2015/16 Non-Recurrent Income | (43.9) | a | (43.9) | |
| 2015/16 Non-Recurrent Costs | 12.3 | | | 12.3 |
| 2015/16 Other Non-Rec | - | | | |
| **Underlying Deficit Cfwd** | **(30.6)** | | **577.8** | **(608.4)** |
| | | | | |
| **2016/17 Changes** | | | | |
| 2016/17 Service Developments | **-** | | **-** | **-** |
| Unwind contract caps / NHSE marginal rate | **4.0** | b | 4.0 | |
| Contracted QIPP / Growth | **-** | b | | |
| CNST increase | **0.3** | c | 2.5 | (2.2) |
| Other Cost Pressures | **(1.7)** | c | | (1.7) |
| Cost Inflation | **(19.7)** | d | | (19.7) |
| Capital Charges changes | **(1.0)** | d | | (1.0) |
| Tariff Inflation (net of CNST) | **5.1** | e | 5.1 | |
| Other Income | **0.5** | e | 0.5 | |
| CIP programme | **20.1** | f | | 20.1 |
| Synergies | **1.6** | f | | 1.6 |
| Contingency | **(2.1)** | f | | (2.1) |
| **Subtotal** | **(23.5)** | | **589.9** | **(613.4)** |
| | | | | |
| Estimated Integration costs | - | g | 7.2 | (7.2) |
| | | | | |
| **Planned Underlying Deficit** | **(23.5)** | | **597.1** | **(620.6)** |
| | | | | |
| DoH Deficit Support (95%) | 46.0 | | 46.0 | |
| | | | | |
| **Net Surplus 2016/17 Monitor Plan** | **22.5** | | **643.1** | **(620.6)** |

***Figure 11, I&E Bridge Analysis***

## 5.3 Financial planning assumptions: basis for calculations

The 2016/17 I&E plans have been calculated using the following assumptions:

### 5.3.1 Calculation of outturn

**Non-Recurrent Items (a) above**
The 2015/16 position includes a number of one-off non-recurrent income totaling £43.9m and has been removed going forwards:

- £1.6m of winter pressures funding which is received as a one-off to manage capacity and demand pressures
- £18.2m of DH deficit support funding
- £13m of additional funding (see above)
- £11m of integration funding matched to costs

The £12.3m of non-recurrent costs are mainly £11m integration costs and costs related to provision of the Farnham ward above budgeted levels.

### 5.3.2 Budget setting

For 2016/17 budgets have been built bottom up and based on forecast outturn as at month 08 adjusted for non-recurrent items. To this a process of executive challenge and peer review will overlay unavoidable cost pressures and efficiency targets. The overall CIP target has been set at 3.4% which amounts to £20.1m. This is based on the original Monitor tariff inflator plus additional stretch required to achieve targets. The phasing of the CIP programme is incremental with a ramping up in Q2 onwards to reflect the recruitment and retention schemes which underpin a large proportion of the in-year savings. In additional to this the plan has planned £1.6m of synergy savings.

## 5.4 Financial planning assumptions: Commissioner plans, income and activity

### 5.4.1 Commissioner plans and activity

**Commissioner plans and activity**
Negotiations with commissioners are currently progressing well. Both commissioners and provider are aligned on the principles for a forecast outturn for 2015/16 and have identified some key issues that impact the 2016/17 contract value:

- **Growth**. The Trust and CCG are expected to share growth expectations in the near future. This will facilitate agreement of a joint view. The Trust has already shared a piece of work regarding capacity and demand carried out by EY for the Trust which includes growth expectations for the coming year. However the Trust has not included growth in this iteration of the plan as this is not yet agreed with commissioners
- **QIPP**. Trust has made the financial planning assumption that broadly QIPP will equal growth. This assumption can be revisited following meetings beginning the 9th February to review Commissioner QIPP expectations.
- **Service Developments**. The Trust has identified a range of Service Developments to the CCGs that will have a material impact in 2016/17. Meetings have been arranged for the week of 9th Feb onwards to discuss the impact of service developments with the Commissioners. Therefore at this time the impact of Service Developments have not been included in this plan.
- **Activity Planning Assumptions (APAs).** The CCGs have not yet provided detailed plans for APAs however they have outlined areas of interest in both Outpatient and Elective inpatient care. This submission does not reflect these at this time.

**New ways of working**: Frimley North and South have implemented Ambulatory Care Units recently and the activity and financial impact of these units during 2016/17 is yet to be agreed. The work to agree the impact has begun but is significant and so it is expected that agreement will be reached in early March. There are also a number of schemes/services which promote integrated working which are being considered during negotiation for a part year impact in 2016/17 (such as the Adult Integrated Respiratory Service, Frail Elderly pathway and Vanguard schemes).

### 5.4.2 Income

Moving from one year to the next, contract negotiations tend to include the Trust asking for activity growth to reflect historic trends, and CCGs asking for activity reductions to reflect their schemes for moving activity out of hospital (QIPP and BCF). At this relatively early stage in the planning process for modelling purposes, we have assumed that QIPP/BCF broadly equals (and therefore cancels out) growth. The model is therefore based upon broadly flat activity. However planned negotiations with CCGs will include a start point that reflects actual activity and so the capping in current contracts is removed. We will update these assumptions in the final version of our Operating Plan and model following further discussion with commissioners and additional modelling work.

The 2016/17 tariff change is an uplift to prices of on average 1.1% plus and element for CNST of 0.7% a total of 1.8%. However, the Trust has conducted a detailed pricing exercise combining outturn activity and the various tariff rules, producing an average increase for Frimley Health of 1.6%.

Other Income is based on a 1.0% increase which reflects the harmonization of treatment across the two former hospitals pricing and management of car parking and private patient income, including overseas patients.

## 5.5 Costs, cost pressures and other key movements

### 5.5.1 Cost pressures

There are a number of new cost pressures impacting the Trust in 2016/17. The CNST premium for FH is set to increase from £19m to over £21m, an increase of £2.2m. As this increase has impacted upon all providers (albeit disproportionately for some), the national tariff has been inflated by (approximately) 0.7% to offset the cost pressure. For FH this gives an income increase of £2.5m and equivalent cost pressure.

The remaining cost pressures of £1.7m across the Trust, relate to a provision for budget bids that will have to be approved by the Executive team. These will be unavoidable cost pressures over and above outturn expenditure

Pay and non-pay costs have been inflated in line with NHS inflation assumptions, which reflect those that have been built into the national tariff (the tariff estimate was a 3.1% weighted average increase). This is higher than is normal because of one-off changes in pension arrangements. Capital charges have been recalculated based upon the existing and projected asset base, incorporating the planned 2016/17 capital programme.

### 5.5.2 Strategic initiatives

Integration costs will be neutral to the Trust income and expenditure account. For planning purposes £7.2m of cost and £7.2m of income have been included within the plan.

There are three major projects in currently in the FBC process development stage. These were included as OBCs in the transaction FBC and all relate to Wexham.

- Redevelopment of maternity unit: capital plan included at £3.6m (£9.5m total)
- Replacement of the Emergency Department: capital plan included at £8.5m (£25.5m total)
- Heatherwood Hospital new build: capital plan included at £3.2m (£78.2m total)

The revenue impacts from capital charges are included but all activity impacts are assumed to be revenue neutral at this stage until the business cases are developed further.

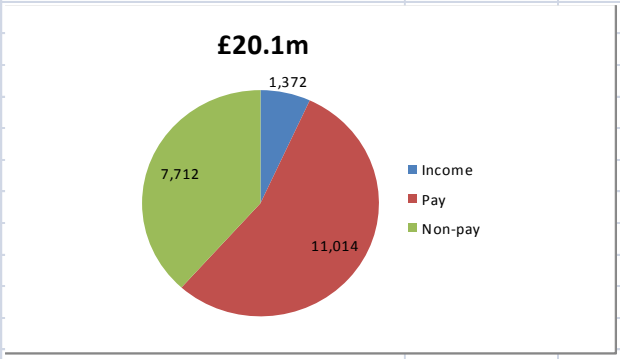
## 5.6 Cost improvement programme

All other things being equal, the Trust CIP (clinical efficiency) comprises the difference between the tariff inflation (income increase) and the Trust inflation expectation (cost increase). From the figures above (including the CNST element) this is £7.6m against £21.9m giving a CIP target of £14.3m. As FH has a significant underlying deficit, the CIP target has been retained at higher figure and included in the plan as £20.1m of cost reduction.

In addition to the CIP reduction, £1.6m has been included as anticipated additional cost reduction synergies being released in 2016/17

However, given recent actual delivery against plan, **a contingency £2.1m has been added** back to reflect the risk on non-delivery of the CIP/Synergy total. This would equate to delivery of just over 88% of the current target, which is in-line with current performance but on the high side and represents a significant challenge for the Trust.

The following tables show the total by directorate and schemes by value above £250k.




| Directorate | Total £'000 |
|---|---|
| Medicine (WPH) | 2,170 |
| Medicine (FPH) | 1,938 |
| Cross Cutting - Pharmacy | 1,583 |
| Orthopaedics and Plastics | 926 |
| Womens and Childrens | 833 |
| Therapies | 356 |
| Informatics | 240 |
| Finance | 160 |
| Information and Contracts | 157 |
| Operations WPH | 136 |
| Education | 78 |
| Outpatient FPH | 75 |
| **Grand Total** | **20,098** |

| Workstreams | Total £'000 |
|---|---|
| Procurement - Savings | 1,617 |
| HR - Cap on agency | 1,000 |
| Theatres - In-session utilisation | 824 |
| Medicine - LoS non-elective | 750 |
| Pharmacy - Contract savings | 675 |
| Theatres - Session utilisation | 627 |
| Pathology - Business case | 572 |
| Theatres - Stock control process | 450 |
| Procurement - Contracting goods servs | 418 |
| Pharmacy - Therapeutics switching | 410 |
| Surgery - Medical agency | 384 |
| O&P - Prosthesis | 380 |
| Medicine - HCAs on medical ward | 330 |
| W&C - Agency reduction | 330 |
| Surgery - Reduction in WLI | 300 |
| Theatres - PP recharging | 300 |
| Therapies - Patient appliances | 300 |
| Estates - Cleanliness | 288 |
| Medicine - Ward closure GP unit | 287 |
| Radiology - CMR patients | 280 |
| Medicine - Monitor Agency cap | 269 |
| Medicine - Reduction in locum use | 265 |
| Medicine - Reduction ED agency | 258 |
| Estates - Catering income | 257 |
| Medicine - Productivity review | 250 |
| Other under £250k | 8,278 |
| **Grand Total** | **20,098** |

***Figure 12, Cost improvement schemes over £250k***

From the above it can be seen that Procurement and agency rules feature significantly in the total programme. The Trust has been involved in the original data collection and 'model hospital' benchmarking initiated by the Lord Carter process. The Trust is currently validating output and data inputs with the Lord Carter team and will use the results to indicate where further opportunities exist or to reduce the delivery expectation gap.

## 5.7 Capital

Capital plans largely follow the strategic spending as outlined in the Acquisition FBC and reflect the Trust's 5 year Clinical Strategy. Key strategic developments include:

- **Heatherwood site redevelopment**: The redevelopment of Heatherwood will provide modern facilities for planned care, and is primarily a replacement of existing facilities although the development will include a small amount of additional capacity, for example the creation of a local lithotripsy facility.
- **Emergency Department and Ambulatory care** at Wexham Park Hospital: This project allows for the co-location of the emergency department and assessment facilities at the front of the hospital, providing improved quality of accommodation and supporting the provision of enhanced ambulatory care which should result in efficiencies for the Trust such as reduced length of stay and which will also potentially support the emerging STP plans for reduced acute admissions

- **Maternity and gynaecology facilities at Wexham Park Hospital**: To provide an improved experience for patients and to enable the Trust to improve care processes, for example the introduction of a transitional care unit in line with best practice standards.

The phasing of spend over the five year period is slightly altered given the delay in starting the projects subject to business cases i.e. Heatherwood Development and modernisation of ED and Maternity and Wexham. 2014/15 outturn excluding the three business case items was £2.4m lower than plan and this slippage has been rolled forward into 2015/16 and beyond. The overall planned spend is £41.2m for 2015/16 of which over £21m is to be spent on estates infrastructure at both acute sites.

The IT strategic programme is allocated over £9m which will be primarily focused on the integration works to embed a common infrastructure for the whole hospital. Medical equipment at H&W will be £3m compared to £0.8m at FPH to reflect the historical underfunding at these sites.

The five year plan is shown in the table below.

| | 15/16 forecast | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | Total |
|---|---|---|---|---|---|---|---|
| **HWPH** | | | | | | | |
| Heatherwood | 2.300 | 3.250 | 10.350 | 30.100 | 23.610 | 8.590 | 78.200 |
| Wexham - Emergency Dept | 0.600 | 8.500 | 12.000 | 4.387 | 0.000 | 0.000 | 25.487 |
| Wexham - Women's and Children's | 0.450 | 3.600 | 3.600 | 1.908 | 0.000 | 0.000 | 9.558 |
| HWP Estate | 8.028 | 12.612 | 12.672 | 12.691 | 7.915 | 0.000 | 53.918 |
| HWP Estate (internal funded) | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 6.500 | 6.500 |
| Information technology (HWP) | 1.150 | 3.579 | 3.542 | 2.900 | 2.720 | 1.500 | 15.391 |
| Medical equipment | 1.700 | 4.527 | 3.231 | 3.311 | 3.394 | 1.000 | 17.163 |
| **HWPH total** | **14.228** | **36.068** | **45.395** | **55.297** | **37.639** | **17.590** | **206.217** |
| **FPH** | | | | | | | |
| FPH Estate | 7.645 | 10.965 | 10.355 | 10.700 | 10.800 | 6.000 | 56.465 |
| FPH - Medical Equipment | 1.130 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 6.130 |
| FPH Information Technology | 2.300 | 4.081 | 3.558 | 3.361 | 2.900 | 1.500 | 17.699 |
| **FPH total** | **11.075** | **16.046** | **14.913** | **15.061** | **14.700** | **8.500** | **80.294** |
| **Integration capital** | **1.100** | **5.659** | **3.910** | **0.000** | **0.000** | **0.000** | **10.669** |
| **Capital synergies** | **0.000** | **-1.603** | **-1.637** | **-1.672** | **-1.706** | **0.000** | **-6.618** |
| **Frimley Health Total** | **26.403** | **56.170** | **62.581** | **68.686** | **50.633** | **26.090** | **290.562** |

*Figure 13, Five year capital plan*

## 5.8 Risk ratings and liquidity

The anticipated capital programme has been included within the financial model largely along the lines of the transaction FBC but with movement in phasing due to slippage on key elements during 2015/16. The worsening I&E position will impact upon cash generation, the original FBC projection was for a cash position (£81.7m at the end of 2016/17). The latest model indicates a cash position of £84.6m – assuming that the STF is cash-backed and that the £22.5m surplus is therefore cash generating.

| Financial Sustainability Risk Ratings | Plan 2016/17 Metric | Rating |
|---|---|---|
| **Capital Service Cover** (internal cash available to cover capital spend) | 59% | **1** |
| **Liquidity** (Cash equivalents % of total expenditure) | 39.21 days | **4** |
| **I&E Margin**<br>**I&E Margin Variance from Plan** | 4.92%<br>2.69% | **4** |
| **Financial Sustainability Risk Rating** | | **2** |

*Figure 14, Forecast risk ratings*

Risk ratings have been calculated as a '2'.

## 5.9 Sensitivity analysis

The Trust has built significant prudency into the plan.

- For modelling purposes, the Trust has assumed that QIPP/BCF broadly equals (and therefore cancels out) growth. The model is therefore based upon broadly flat activity. Overperformance will be dealt with in year on a cost and volume basis.
- It should however be noted that the contract values that have been included in the plan include 80% CQUIN (quality plans) delivery of 2.5% of contract value. This is to provide an element of cover for in-year risk given that 100% achievement (for example) would provide in excess of a £2m additional income.
- The plan does include £2.1m of cost contingency (anticipated to offset potential CIP under delivery or additional in-year cost pressures).
- As mentioned above the Trust is engaged in work to ensure the deficit plan is significantly improved in year. The Board has been presented with a recovery plan that outlines actions that are being taken to reduce this deficit.
- In line with the arrangements agreed with the DoH, £19m of deficit support revenue has been included in the plan. This represents 95% of the maximum that could have been obtained, in line with the agreed risk-share arrangements. In additional to this £5m of integration funding has been included with the more recent agreement of DH and the full amount of the Sustainability and Transformation Planning incentive of £22.5m has been included.

# 6. Sustainability and Transformation Plan

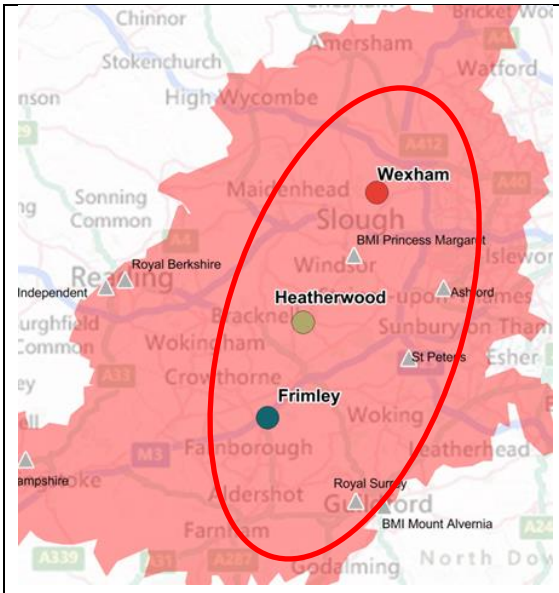
## 6.1 Introduction

The Sustainability and Transformation Planning (STP) process is in the early stages at time of writing this draft Operating Plan. We envisage that we will include greater detail on the emerging STP in our final Operating Plan when this is submitted in April 2016.

## 6.2 Vision for the local health and care system STP

### 6.2.1 Emerging Strategy

Frimley Health NHSFT sits within a complex Health and Care system, which consists of six Clinical Commissioning Groups, three County Councils and three District Councils. The Health and Care System also falls within the boundaries of three different NHS Area Teams. Figure 15, below shows the footprint for our STP. This has been proposed to NHS England in January 2016.




| Partner | Existing transformation work |
|---|---|
| All CCGs | Transformation pathway work with a focus on Elderly Care |
| North East Hampshire & Farnham CCG | PACS Vanguard Programme |
| Surrey Heath CCG | Integrated Care Programme |
| Chiltern CCG | Exploration of PACS model |
| Slough CCG | New Vision of Care |
| Windsor, Ascot and Maidenhead CCG | New Vision of Care |
| Bracknell & Ascot CCG | New Vision of Care |

***Figure 15, Planning footprint for STP (Note: can be edited or HB can commission a special one showing CCGs)***

Figure 15, above gives a brief summary of our existing transformation work with the six CCGs who form the Frimley Health and Care System. There are a number of common themes across the current and emerging plans from our partners and from our own transformational work:

- **Supporting people to stay well:** This includes action to prevent ill health and to promote healthy choices; education and active support for self-care and self-management
- **Preventing crisis:** Identifying patients who need care by using shared risk processes, case finding, & shared assessment, in order to pre-empt crisis and avoidable admission to hospital.
- **Enhanced primary care, and locality based integrated multi-disciplinary teams:** Enabling patients to receive the majority of their care in their local area from a multi-skilled team with their GP and practice at its core, including social care in some areas.
- **Breaking down the barriers between hospital and out-of-hospital care:** For example North East Hampshire & Farnham GPs are now working in Frimley Park Hospital A&E department, hospital consultants supporting locality based care, and previously separate teams from acute, community and social care working as one to avoid admissions and minimise delays in hospital.
- **Use of technology as an enabler:** Development of a fully intra-operable record that can also be accessed by patients, under the 'share my care' programme in Berkshire and similar initiatives with other partners.
- **Increased use of ambulatory care:** This is one of the Trust's own transformation projects and it is congruent with the themes described above

We anticipate that the STP vision will be based upon these themes and system design principles with the inclusion of new ideas as they emerge during the planning process.

Whilst there is a reasonably consistent vision for the future across the six CCG within our health and care system it should be noted that there are also some differences in the detailed approaches and timescales for implementing this transformation process. This potentially presents operational challenges to the Trust, and we hope to use the STP process to develop a more unified approach and implementation plan with our partners.

### 6.2.1 Engagement and governance

Frimley Health is actively engaged in the projects listed in figure 15, above through existing forums such as the System Leaders Group, which brings together Local Authorities, Commissioners and Providers from East Berkshire and South Buckinghamshire and the Joint Transformation Programme Board, which includes membership from the East Berkshire and Chiltern CCGs and which is the legal structure within which Frimley Health and commissioners monitor progress following the acquisition transaction.

At present the process and forum to develop the STP has not been agreed for our Health and Care system, and our hope is that this will be addressed as an early priority during the STP development process following the recent agreement of our Health and Care system footprint.

## 6.3 Impact upon Frimley Health

The Frimley Health Transformation Team has started to consider the impact of the early strategic thinking described above upon our 2016/17 operational plans. Figure 16, below, sets out what we believe the impacts and risks to us may be, together with the strategies that we are starting to develop to address these.

| Emerging strategic aim /issue | Impact upon Frimley Health | Operational Plan Response |
|---|---|---|
| **Emphasis upon crisis prevention and staying well at home** | • Potential reduction in admissions, particularly for non-elective work<br>• Risk of reduced income | • Modest growth assumptions in demand and capacity plans compared to previous years (3% NEL and 5%EL)<br>• Continued LOS reduction at WPH<br>• Flexible bed capacity plans, e.g. use of community beds |
| **Ambulatory care model** | • Change type of beds/service required at front end of hospital<br>• Potential reduction in NEL admissions and LOS, with reduction in income | • Capital plan for WPH emergency development based upon an ambulatory care model, with reduced LOS and faster turnaround of patients<br>• Further develop ambulatory care model for FPH to improve LOS and appropriate patient care in right context |
| **Breaking down the barriers between hospital and out-of-hospital care** | • Potential opportunities to develop vertical integration/development of new services<br>• Risk of reduced income | • Development of multi-skilled workforce, e.g. employment and secondment of Care Assistants<br>• Exploration of commercial opportunities for provision of community services during FHFT strategic development process |
| **Social care pressures** | • Potential increase in DTOC and patients defaulting to A&E in absence of social support | • Exploration of commercial opportunities to provide social care staff within FPH system<br>• BCF opportunities to pilot new models |

***Figure 16, operational impact of STP***

At this early stage in the STP development process clearly defined milestones for 2016/17 have yet to be agreed for much of the programme, although there are some exceptions to this, most notably the North East Hampshire & Farnham PACS Vanguard Programme and the New Vision of Care programme with east Berkshire/south Buckinghamshire CCGs and partners. More concrete milestones will be included in the final version of this Operational Plan.

# 7. Membership and elections

## 7.1 Governor elections and engagement

Following the acquisition in October 2014, FH has been engaged in reshaping the composition of the Council of Governors. Throughout September and October we have held elections for twelve Public Governors in five constituencies (Rushmoor; Surrey Heath and Runnymede: Hart and East Hampshire; Guildford, Waverley and Woking; and Bracknell Forest and Wokingham) in accordance with our Constitution. These elections marked 'Phase 2' of the overall approach to reshaping the composition of the Council of Governors post-acquisition.

As a result of the elections, the overall number of Public Governors for Rushmoor; Surrey Heath and Runnymede; Hart and East Hampshire; Guildford, Waverley and Woking; and Bracknell Forest and Wokingham reduced from 19 to 12. The size of the Council of Governors will now remain static at 37, as the allocation of Governor seats will be proportionate to the population of each individual constituency across the Trust. Elections will be held each summer in line with our Constitution.

The Trust works hard to engage with and to inform our Governors. All new Governors participate in a formal induction process. Governors contribute to a wide range of hospital working groups and committees, including the Hospital Infection Control Committee and the Non-Executive Performance and Remuneration Committee and in strategic development through Board and Council of Governors workshops.

Our Governors also lead a process of engagement with our members and with the public through their leadership of the Patient Experience and Involvement Group and the Community Engagement Group and through local Constituency meetings.

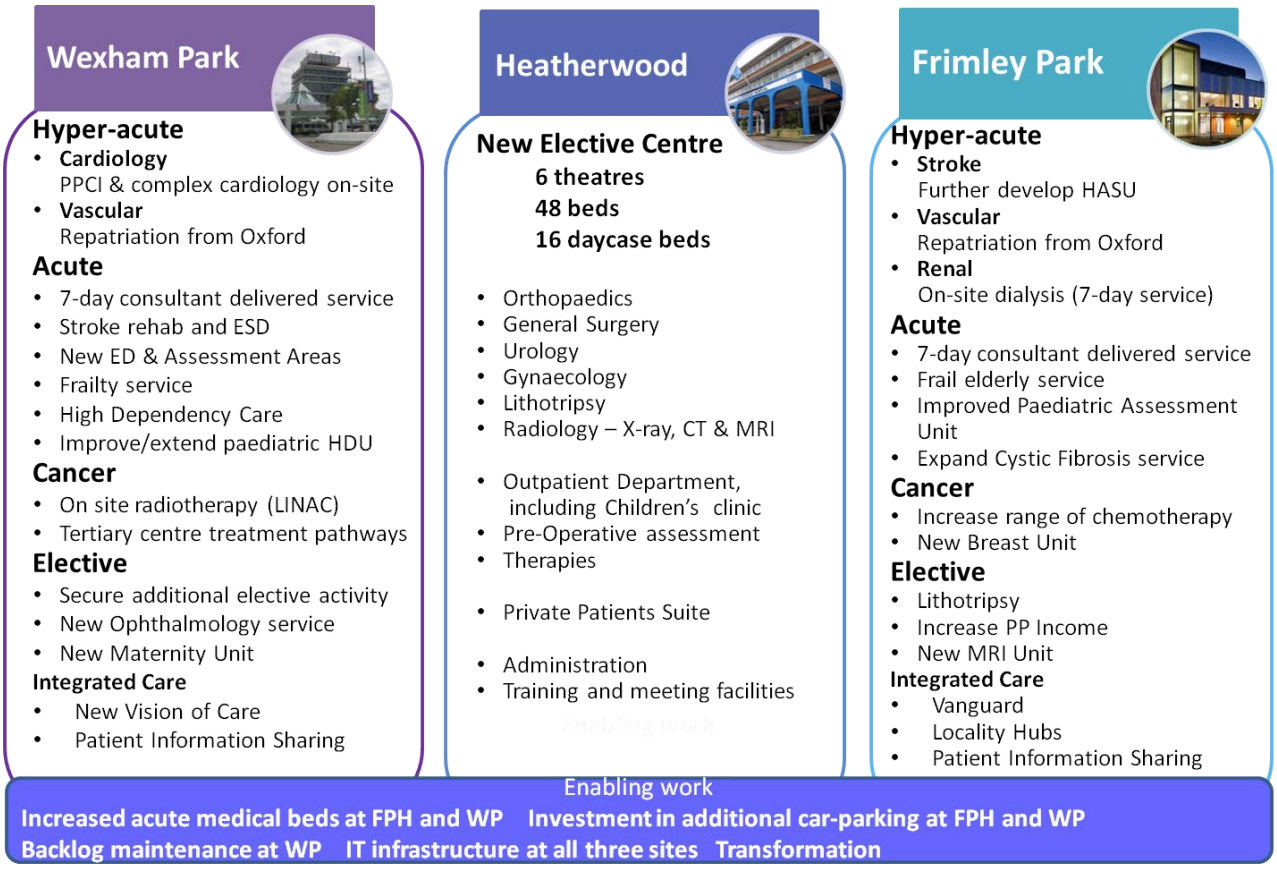
## 7.2 Membership strategy

The Trust runs a full programme of events and communications to recruit and engage with its 24,000 members. Each year, a series of events is held in each different membership constituency with a presentation on the Trust from a member of the Executive team and a clinical presentation on a service or condition by a senior clinician. These are very popular with audiences of 80 – 160 the norm. Governors host these events offering members and the public an opportunity to discuss matters face to face with them.

We also publish a newsletter which is distributed to members – staff and public – highlighting the latest developments across the Trust for those unable to make the events. This is also supplemented by membership information and online recruitment via our website.

Members are also encouraged to become involved with the Trust through other routes – volunteering, fundraising, careers events etc. They are also involved in public engagement work – for example members were recently invited to participate in the development of women's and children's services at Wexham Park Hospital.
Following the creation of Frimley Health a successful drive to recruit members on the former Heatherwood and Wexham Park catchment areas was undertaken. The longer term model will be to grow membership slowly and steadily over time, maintaining an optimum number. Focus will shift from number of members to the diversity of membership reflecting the new catchment population.

## Appendix 1, Summary of Frimley Health 2015 – 2020 Clinical Strategy




[i] Care Quality Commission, 'Frimley Health NHS Foundation Trust Wexham Park Hospital Quality Report', 02/02/16

Committed To Excellence | Working Together | Facing The Future

Frimley Health NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Meeting Date: 4th March 2016**

| |
|---|
| **Title: Clinical Governance Committee Report** |

| |
|---|
| **Purpose:** To inform the Board of the issues discussed and decisions made at the Clinical Governance Committee Meeting held on Tuesday 9th February 2016. |


| |
|---|
| **Summary:** The Bullet Points are subject to confirmation at the following Committee meeting to be held on Tuesday 8th March 2016. |


| |
|---|
| **Recommendation:** To discuss and note the main issues. |

| | |
|---|---|
| **Prepared by:** Carole Davis<br>PA to Medical Director | **Presented by:** Timothy Ho<br>Medical Director |

Frimley Health NHS
NHS Foundation Trust

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# *Clinical Governance Report*

Report covering the Clinical Governance Committee meeting held on ***9th February 2016***.
**NEDs in attendance: Dawn Johnson.**

The key points to note are as follows:

**6-MONTHLY UPDATE FROM GENERAL MEDICINE:**
**Dr John Seymour, Chief of Service – General Medicine**

**FPH:**

- Emergency Medical Admissions demonstrated a steady increase, with a particular spike in December 2014 and January 2015, and the highest number of weekly spells during January 2016.
- Medical Assessment Unit (MAU), which had discharged approximately 38% of patients directly. LoS on MAU had dropped from 2.07 days to 1.6 days.
- LoS was regarded as a crude metric, with variance between sub-specialties.
- Re-admissions benchmarked nationally; some areas in the median to upper quartile and several areas in the upper quartile. Reporting re-admissions organisationally had only begun in recent months and further work was required on the exact coding/definition of re-admissions and whether some assessments were being recorded as such. Concerns had been raised by Surrey Heath CCG regarding an increase of 32% in re-admissions after 7 days and it was suggested that clarification be sought with the CCGs regarding the definition of a re-admission.
- Changes introduced to try and meet increased demand:
    - introduction of an Ambulatory Care Unit in mid-November 2015, aimed at assessing patients' requirements, sending them home the same day if safe to do so, and bringing them back for appropriate treatment/investigations
    - changes to rotas to increase Consultant cover, particularly at weekends
    - increased junior doctor presence in all zones at weekends. Anticipated that it might improve VTE and antimicrobial compliance.
- Five conditions had been identified which accounted for approximately one third of the additional spells over the last year.
- Demands on respiratory, ADU and CF were outlined:
    - predicted increase of 50% in the population with CF.
    - Challenges included Consultant staff establishment; SIRI reviews of 5 falls with fractures; providing a 7-day service, including weekend ADU ward rounds, and outpatient activity, particularly with regard to sleep patients.
- Cardiology experienced stable LoS, but with higher variance, and excellent compliance with door to balloon times (93% < 60 minutes). Only half of NSTEMI patients reached a cardiac zone as quickly as preferred, and 21% waited >2 days for Inpatient angiography.
- Stroke LoS had increased from 7.1 to 8.5 days, with a high re-admission rate.
    - Time to CT imaging had improved. 68% of patients in the year-to-date had reached the Stroke Unit within 4 hours. The Stroke Service had achieved an SSNAP A-rating, one of only a few Units in the country.
- Endocrinology, Gastroenterology and Care of the Elderly: staffing establishment in Gastro and CoE raised.

- The Safety summary focused on falls (8 falls with fracture, 5 of which occurred on G5), C.Diff and other markers, and outlined the actions being taken. Hand hygiene compliance had increased to >90% in December 2015.
- 62-day Cancer targets, whilst Dermatology had achieved target in all quarters. Thoracic and haematology cancer targets to be improved: issues related to small numbers, but all 31-day targets had been met. Work was on-going with various MDT cancer leads.

**Discussion points:**

- A dedicated telephone number to reduce re-admissions had been successful in Surgery; Medicine did offer the same facility but not had the same reduction. Ambulatory Care aims to provide greater benefit.
- The issues around retrieving TTOs from Pharmacy were debated at some length.

**WPH:**

**Dr Derek Hilton, Directorate Clinical Governance Lead**

- The results of the recent CQC report were outlined, with Medical Care (including older people's car) rated as Good.
- Significant differences existed in governance between the 2 sites, aim was to align them. Future plans:
    - training for medical staff on incident reporting; junior doctor attendance at M&M meetings; medical records (Trust-wide); application of DoC policy; staffing recruitment and retention |(Trust-wide), and robust audit trail of medications delivered to Wards (Trust-wide).
- Since July 2015 all specialty guidelines had been reviewed/updated and made available on the Intranet; national and local audit discussions and actions/accountability at specialty clinical governance groups had been improved, and specialty attendance at Directorate Clinical Governance meetings had been reviewed.
- The most commonly reported incidents were outlined.
- Incident reporting was focused on with each new intake of trainees in order to improve compliance. No Never Events had occurred. Lessons learnt Newsletters were used to disseminate learning.
- VTE and Dementia compliance required reinforcement on occasions.
- Friends and Family responses were above target. Each specialty was presented with the comments, positive and negative, at their monthly Clinical Governance meetings and were asked to comment. No particular themes had been identified in any specialty.
- The Risk Assurance Framework demonstrated that the main risks were nursing staffing, particularly in Acute Medicine and Elderly Care; the ageing CT scanner; C.Diff rate in Medical Wards; clinical documentation standards.
- M&M had been encompassed within governance, but each specialty was developing separate M&M meetings to review all deaths. Attendance was improving and learning was identified and disseminated appropriately. A new IT-BASED Trust M&M form had been launched in February 2016 to audit outcomes. CRAB, HSMR and SHMI data was regularly shared and discussed with specialties.
- Future plans included the appointment of a new Clinical Governance Facilitator; a new Quality & Audit Manager (previous CGF) for the Wexham site, whose aims would be to improve audit presence and link with clinical governance; identification of actions required in Medicine following the CQC report; standardisation in the quality of specialty M&M meetings, and the establishment of a Mortality Surveillance Group in line with NHS England recommendations.

**Discussion points:**

- Currently there were no CGFs at Frimley, but a structure was being developed to work across specialties and support both sites to develop a consistent approach.
- The Medical Director commended the approach, led by Derek Hilton and Claire Stapleton, of reviewing the notes of every single deceased patient in the Bereavement Office, as excellent practice.
- The Medical Director also commended the efforts involved in delivering the recent CQC result.
- A Public Governor who had visited the Stroke Unit at Wexham Park had been very impressed and expressed disappointment at the political decision to base the service at High Wycombe. It was reported that the national move was towards fewer bigger centres. Data indicated that patients were 20% more likely to survive a stroke if they spent the first 3 days in a Hyperacute Unit.

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**PRIVATE PATIENT SERVICES REPORT:**
**Alastair Davidson, Clinical Lead for Private Patient Services, FPH**
**Angela Lawes, Private Patient Services Manager, FPH**
**Pam Morrison, HoN accountable for Parkside on behalf of Sally Hannaway, Matron**

- Recent innovations included the introduction of a private GP service; redesign and promotion of the brand; improvements to the billing system and refurbishment of the Parkside Suite.
- PP facilities consisted of Parkside at Frimley – 37 beds, 6 consulting rooms and 2 treatment rooms and Paragon at Wexham – 17 beds due to be converted to 15 beds and 2 consulting rooms – as well as possible inclusion in the redevelopment of Heatherwood.
- **Safety:** a safe service was Consultant-led and delivered, with clear Consultant cover arrangements and strong support from junior doctors. Nursing handover each morning was clear and effective, and communication between all areas and levels of staff was considered excellent.
- **Incident Reporting:** all incidents were discussed at the Parkside PPMAC. Paragon required further work but a new KPI reporting tool would be used to standardise reporting across the Trust and allow comparison.
- **PEAT** scores were excellent: housekeeping achieved 95-100%, averaging 97% and nursing staff achieved 71-100%, averaging 97%.
- **Infection Control:** More sinks for hand washing had been installed during refurbishment. Two cases of C.Diff in October 2015 had been deemed unavoidable on Root Cause Analysis and the Department was satisfied that they had not originated on Parkside.
- **Drug Error Monitoring & Reporting:** all drug errors were investigated by the Matron, reported to and discussed at the PPMAC. No drug errors resulting in patient harm had occurred during 2015.
- **CQUIN:** Safety thermometer compliance consistently 100%. VTE assessment improved to between 97 – 100% following the re-design of the drug chart.
- **Staffing:** levels of vacancies remained similar to previous years. The focus of the Unit was on continuing to maintain a high standard of recruitment of permanent nursing staff.
- **Training & Appraisals:** all staff were either up to date or had dates organised.
- **Effective, Caring, Responsive:** The Unit prided itself on providing high quality senior support for nursing and other staff. The use of mentoring and buddying systems

worked well, with morale high and an excellent standard of caring for patients and staff. High scores had been received from Friends & Family tests.

- **Well-led:** the management leadership structure was outlined.

**Challenges:**

- NHS bed usage on Parkside represented a continuing challenge.
- Consultant body continued to be urged to maximise use of Theatre capacity. Utilisation was currently at 60% aiming for at least 70%.
- The Parkside Unit continued to be involved and work with the Trust with regard to the development of facilities at Heatherwood Hospital, using feedback from Consultant colleagues in terms of requesting Theatre and outpatient space.
- Parking remained a major issue for patients/visitors. Recent changes to traffic flow on the roads and new car park had helped, but patients were still being lost to competitors because of this issue. The CEO commented that once the residences at the back of Frimley Park Hospital had been demolished this may provide an opportunity to address dedicated parking for Parkside.

**Discussion points:**

- The positives and negatives of offering private patient services, NHS bed usage, income streams and infrastructure, were discussed in detail.
- It was recognised that further work was required to change culture and bring the Paragon in line with Parkside.
- Some discussion took place regarding appropriate allocation of patients; any issues at weekends/Out of Hours, and tracking whether patients were NHS or private in terms of Safety and Quality. Any concerns were always flagged/escalated by nursing staff.

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**NIGHT SITE MANAGEMENT TEAM REPORT:**
**Fiona Sayers, Associate Director of Site Management, FPH**

- The structure of the Site Team was outlined, which included the HIT Team, Night Nurse Practitioners, Discharge Team, Discharge Lounge, Transport, Patient Flow Managers and the Site Manager (Bleep 030).
- The Discharge Lounge was not fully funded, but recruitment of 2.58 carers and one Band 5 nurse had been agreed but an uplift to a band 6 had been agreed. A member of staff was available to transfer from Wexham Park if this was agreed – the CEO confirmed the uplift.
- Night Nurse Practitioners covering the Stroke Co-ordinator role was acceptable as a contingency measure, but should not represent the norm. In response it was stated that this was a temporary. Evidence suggested that most stroke calls occurred Out of Hours, so it may be necessary to redeploy Stroke Co-ordinators at night,.
- An initial Capital Projects application for 2 trolley spaces and a disabled toilet in the Discharge Lounge being resubmitted. These facilities would help with reducing LoS and improving patient flow. Governance issues would include changing the admission policy, provision of medications and provision of transport.
- Transport: 2 ambulances owned by FPH, run by 2 FPH crews. Funding agreed for 2.85 wte Band 3s and Band 2s, constituting sufficient uplift to provide oxygen therapy and additional manual handling. The necessary training was arranged for 29th February, to Go Live on 1st March.
- Patient Flow Managers: funded establishment 14.2 wte, currently 10.07 in post with a deficit of 4.13 wte. Day team covers ED 4-hour target and beds with support from Bleep 030 provided from the Wards on a rota system. Night team covers ED 4-hour target and beds; Bleep 030 provides clinical support to the wards and also deals with

staffing/sickness; drugs/medication issues and any other service issues such as Estates, IT, Fire. A new sickness report form for medical staff had been developed and a pilot of medical staff reporting to 030 was due to commence imminently.

- A major issue for 2015 had been building the bed management team up to establishment. This was a difficult job and recruitment was challenging. The current establishment was just over 1 wte short, but the junior staff within the team were excellent and very efficient.
- The title of the holder of Bleep 030 was changing from 1/3/16 to Senior Duty Nurse, in line with Wexham Park hospital, as it was felt that the term "Manager" was causing some confusion. Senior staff from the medical and surgical wards covered the rota, with the ED coming on board. Further training is planned for 17th & 20th May 2016. An increased number of staff made the role less onerous and provided an overview/awareness of what was happening within the Trust.
- Capital Planning had approved the development of an Ops Room and Discharge Lounge; staff had been recruited to the Night Site Management Team; a Site Management Awayday had taken place; the British Red Cross were sited within the Discharge Lounge, providing up to 6/52 support for patients; a reporting dashboard was now in place, and funding was in place to staff the discharge lounge and transport crews. Future work included investigating site options for development of an improved Discharge Lounge; F&F audit of the patient experience whilst in the Discharge Lounge, and identification and training of Ward Ambassadors.
- An Action Plan had been developed to address the various issues highlighted. The vision for the future was to have an all-inclusive integrated team, with all teams funded and internal cross-cover from teams. This would provide senior clinical support to all ward areas, enabling efficient patient flow.

———————————————————————————

**INFECTION CONTROL REPORT:**
**Amanda Walker, Consultant Nurse Infection Prevention & Control**

- 2 post-48 hour MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemia cases to date. Both at Wexham Park Hospital. Both cases agreed to be unavoidable at Post-Infection Review (PIR).
- 39 Trust-apportioned *Clostridium difficile* Infection (CDI) cases to date. Root Cause Analysis of the cases to date have identified 12 lapses in care (8 at FPH, 3 at WPH), 10 relating to antibiotic prescribing that did not comply with Trust guidelines; one relating to lack of hand hygiene consumables in a side-room at FPH, and one due to a delay in sending a stool sample for testing. Trust target <31 lapses in care.
  To date, there have been six 'periods of increased incidence' (PII) (WX5, WX7, G9, Critical Care and 2xF9).
- Hand hygiene audits at Frimley Park Hospital = 91%. The hand hygiene compliance of Drs and Registered Nursing staff has improved to above 95%, for Unregistered nursing (84%) and ancillary staff (85%).
- Hand hygiene at Heatherwood and Wexham Park Hospitals = 74%. The lowest scores were for Doctors (all grades) = 40%. The low score puts the hospitals at risk from norovirus ward closures. Observation during audit has shown that most opportunities for hand hygiene are missed when staff members wear gloves but do not remove them for hand cleaning. The Deputy Medical Director has emailed all Consultants to ask for their help in improving compliance.
- The quarterly Pharmacy audit of compliance with the antibiotic prescribing care bundle at FPH in December, showed an improvement on the previous two quarters to 74%. The short time-frame audits carried out by the junior Drs have continued to show low

compliance with the care bundle, with eight Directorates scoring an average of below 80% for 2015.

- Pharmacy audit of compliance with the antibiotic prescribing care bundle at HWP was presented to the January HICC and has improved to 74%.
- The SSI surveillance rates for Frimley Park Hospital for the July-September 15 quarter are 0% for both hip and knee replacement categories.
- The SSI rates for Heatherwood for the April-June 15 quarter were 0% for hip replacements, and 0.9% for knee replacements.
- Theatre 4 at Heatherwood is currently undergoing work to improve the air handling.
- All Microbiology posts are filled at Frimley Park Hospital: The Nurse Consultant resource has been across all sites since October 2014. Interviews for the Infection Control Doctor post have just taken place for Heatherwood and Wexham Park. Two Locum Microbiology Consultants are in post to support the two substantive Microbiology Consultants. Three nursing team posts are currently vacant. The Lead Nurse for Infection Control for HWP is now in post.

**Discussion Points:**

- The Committee discussed the continuing need to maintain the focus on antibiotic prescribing and hand hygiene in order to combat C.Diff. Engagement and acceptance of the RCA process at Wexham Park had improved significantly. A more cohesive Infection Control Team had been established across all 3 sites, with Consultant recognition of accountability and established regular RCA meetings at FPH and WP. With regard to the periods of increased incidence on Ward F9, it was confirmed that ribotyping had not identified any links or cross-infection.

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**ESSENTIAL TRAINING REPORT:**
**Claire Quinn, Head of Learning & Organisational Development**

- Overall compliance with induction and training was increasing – close to 100% on Corporate Induction for permanent staff, rotational medical staff and temporary contractor staff. No data available for other temporary staff.
- The appraisal tracker had been reinstated onto the shared portal in September 2015, with 57 staff across the organisation trained to use the appraisal tracker spread sheets and file sharing portal, and to input all data. Doctors were covered by revalidation, and the same would soon apply to nursing staff but other staff groups had lower appraisal rates. Significant discussion took place regarding possible methods of addressing this issue.
- Mandatory and Statutory Training (MAST): WIRED had become unsuitable as a reporting system for MAST and work to report from OLM was underway, with an anticipated completion date of June 2016. Local reporting continued on a monthly basis to Tier 2 and 3 managers, and Chiefs of Service, with a monthly report to the Quality Committee. ESR was being used to report to individuals on their compliance. Following discussion, it was suggested that this should be recorded as a metric on Directorate dashboards. **ACTION: CQ to discuss with AI.**

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**MANAGEMENT OF CONTROLLED DRUGS REPORT:**
**Philip Kirkpatrick, Deputy Chief Pharmacist**

- A recommendation to adjust the reporting schedule to tie in with reporting timelines for the Controlled Drug Local Intelligence Network was AGREED.
- Themes from this report should also be submitted to the Safer Medicines Practice Group.
- A recent spike on the graph: it was reported that many of these related to small numbers and that pump errors and administration errors were being captured which had not previously been recorded. The numbers were comparable with other hospitals of a similar size. There was a positive reporting culture at FPH and it was suggested that a combined report would give a better sense of whether or not the figures were unusual.
- Regular audits were undertaken regarding drug storage, but the main area of concern was record-keeping and documentation. 95% of stock discrepancies related to record-keeping and failure to document administration in the Controlled Drugs register. Nursing staff identified would be asked to undertake reflective practice in the first instance, and repeat offences would be escalated appropriately. It was suggested that there was a strong case for asking Ward Managers to take responsibility.
- Future reports would be combined across the 3 sites.
- It was confirmed that no external inspections had taken place during the reporting period.
- In response to a query as to how quickly/sensitively the incident reporting trend would identify any abuse of the system, it was reported that this would only be highlighted following 2-3 incidences, but other steps, such as the uniquely marked holographic sticker, ensured that the CD register was tamper proof.

# Acronym 'Buster'

## A

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting / Annual Governance Meeting
- AHP - Advanced Health Professional
- AKI - Acute Kidney Injury
- AMM - Annual Members Meeting
- AMR - Antimicrobial Resistance
- AMU - Acute Medical Unit
- AOS - Acute Oncology Service
- ANP - Advanced Nurse Practitioner
- AR - Annual Report
- ASPH - Ashford and St. Peter's Hospital

## B

- BAU - Business As Usual
- BBE - Bare Below Elbow
- BME - Black and Minority Ethnic
- BCF - Better Care Fund
- BMA - British Medical Association
- BMI - Body Mass Index
- BoD - Board of Directors

## C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CAU - Clinical Assessment Unit
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- CDI - Clostridium Difficile Infection
- CDIC - Commercial Development and Investment Committee
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CFO - Chief Finance Officer
- CHC - Continuing Health Care
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Continuous Improvement Plan
- CoG - Council of Governors
- CoS - Chief of Service
- CoSRR - Continuity of Service Risk Rating
- CPA - Care Programme Approach
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRAB - Copeland's Risk Adjusted Barometer
- C.Section - Caesarean Section
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography
- CVC - Central Venous Catheter

# D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DoN - Director of Nursing
- DoO - Director of Operations
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

# E

- E&D - Equality and Diversity
- EAU - Emergency Assessment Unit
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ECIST - Emergency Care Intensive Support Team
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EDMS - Electronic Document Management System
- EEG- Electroencephalogram
- EHR - Electronic Health Record
- EHRC - Equality and Human Rights Commission
- EIA - Equality Impact Assessment
- ELSCS - Elective Caesarean Section
- EM - Emergency Medicine
- EMLSCS - Emergency Caesarean Section
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EOLCA - End of Life Care Audit
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record
- ETP - Electronic Transmission of Prescriptions
- EEA - European Economic Area

# F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FH - Frimley Health
- FOI - Freedom of Information
- FPH - Frimley Park Hospital
- FRR - Financial Risk Rating
- FT - Foundation Trust
- FTE - Full Time Equivalent
- FPH - Frimley Park Hospital
- FYE - Financial Year End

# G

- GI - Gastrointestinal
- GMC - General Medical Council
- GMS - General Medical Services

- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

# H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEB - Hospital Executive Board
- HED - Healthcare Evaluation Data
- HEKSS - Health Education Kent, Surrey and Sussex
- HETV - Health Education Thames Valley
- HICC - Hospital Infection Control Committee
- HoN - Head of Nursing
- HSE - Health and Safety Executive
- HSMR - Hospital Standardised Mortality Ratio
- HTC - Hospital Transfusion Committee
- HWB - Health and Wellbeing Board
- HWD - Heatherwood
- HWP - Heatherwood and Wexham Park
- HWPH / H&WPH - Heatherwood and Wexham Park Hospitals

# I

- I&E - Income and Equity
- IC - Information Commissioner
- ICM - Integrated Case Management
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPCN - Infection Prevention and Control Nurse
- IPCT - Infection Prevention and Control Team
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

# J

- JAG - Joint Advisory Group

# K

- KPI - Key Performance Indicator

# L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LINAC - Linear Accelerator
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

# M

- M&M - Morbidity and Mortality
- MAU - Medical Assessment Unit
- MDT - Multi-Disciplinary Team
- MHPS - Maintaining High Professional Standards
- MIDU - Medical Investigations Day Unit
- MiG - Medical Interoperability
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Methicillin-Resistant Staphylococcus Aureus

# N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHS FT - NHS Foundation Trust
- NHSE - NHS England
- NHSLA - NHS Litigation Authority
- NHSP - NHS Professional
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

# O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OLM - Oracle Learning Management
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy

# P

- PACS - Picture Archiving and Communications System
- PACU - Post-Anesthetic Care Unit
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PAU - Paediatric Assessment Unit
- PbR - Payment by Results
- PCI - Percutaneous Coronary Intervention
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PEAT - Patient Environment Action Team
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PILS - Patient Information Leaflets
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMS - Personal Medical Services
- PMO - Programme Management Office
- POD - Pre-Operative Department

- POSSUM - Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity
- PPE - Personal Protective Equipment
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

# Q

- QA - Quality Assurance
- QAC - Quality Assurance Committee
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

# R

- RAF - Risk Assurance Framework
- RAG - Red Amber Green
- RBH - Royal Berkshire Hospital
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RSCH - Royal Surrey County Hospital
- RTT - Referral to Treatment

# S

- SADU - Surgical Day Unit
- SAU - Surgical Assessment Unit (FPH) / Surgical Assessment Unit (WPH)
- SCAS / SCAmb - South Central Ambulance Service
- SDIP - Service Development and Improvement Plan
- SHMI - Summary Hospital-level Mortality Indicator
- SHO - Senior House Officer
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO - Serious Incident Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SME - Subject Matter Expert
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SPS - Surrey Pathology Service
- SSI(S) - Surgical Site Infections (Surveillance)
- SSNAP - Sentinel Stroke National Audit Programme
- SSS - Short Stay Surgical Unity
- SUI - Serious Untoward Incident

# T

- TIA - Transient Ischaemic Attack
- TLC - Turn off, Lights out, Close doors
- TMG - Theatre Management Group
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

# U

- UCB - Urgent Care Board
- UI - Untoward Incident
- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

# V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

# W

- WHO - World Health Organization
- WLI - Waiting List Initiative
- WPH - Wexham Park Hospital
- WTE - Whole Time Equivalent

# Y

- YTD - Year to Date